HEALTH REFORM IN THE DISTRICT OF COLUMBIA

ING

COMMITTEE ON THE DISTRICT OF COLUMBIA HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

ON

HEALTH CARE: COST AND ACCESS ISSUES

APRIL 19, 1993

Serial No. 103-3

Printed for the use of the
Committee on the District of Columbia

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STAFF SUMMARY OF FINDINGS AND CONCLUSIONS

On Monday, April 19, 1993, the Committee on the District of Columbia held a hearing on national health insurance reform and the potential implications for residents of the District of Columbia. During the hearing, the impact of three specific national health insurance reform proposals were examined. The potential affect on access to care and cost of insurance coverage were among key factors considered.

In opening the hearing, Chairman Pete Stark commented that while focusing on the District of Columbia, the findings of this hearing also are relevant to other States, particularly those with large urban populations.

Oral and written testimony was taken from representatives of insurance companies, hospitals, and community clinics as well as physicians and other health care providers operating in the Washington, DC. area. Additional testimony was provided by David Coronado, acting commissioner, D.C. Commission on Health Care Finance and John Shiels, vice president of the health care consulting firm Lewin-VHI, Inc.

National Health Insurance Reform Options

In advance of the hearing, witnesses were provided summaries of three of the most prominent national health insurance reform plans under consideration by Congress and were asked to comment on each. The options considered were a managed competition proposal, a pay-or-play option, and a single payer plan.

The primary component of the managed competition proposal for the District would be the creation of a large purchasing pool, with individuals securing their insurance through a menu of insurance plans offered. All residents—including medicaid-eligible persons—would secure coverage through the purchasing group. For medicaid-eligible individuals, the Government would reimburse the purchasing pool for the cost of the lowest cost plan offered. Advocates of this option anticipate that cost containment would occur as a result of insurers competing with each other for enrollees.

The pay-or-play and the single payer reform options considered would have a "medicare-type" reimbursement structure implemented industry-wide in order to contain health care cost inflation. Both plans would offer enrollees freedom of choice of providers, including solo practice physicians or health maintenance organizations. The most significant difference between these two options is that the pay-or-play proposal would provide employers the option of securing health insurance coverage through the private insurance market or through a public plan. The single payer approach would provide universal coverage to a basic set of health benefits

similar to those found in the Federal Medicare Program. Supplemental coverage to the basic benefits package—to cover copayments or additional services—could be secured through private insurance carriers.

Health Indicators Highlight Serious Problems in the District

Comparisons to national averages, as well as comparisons among groups in the District, revealed that the health status of large segments of District residents is seriously deficient. The infant mortality rate in the District stands at 21 per 1,000—higher than any State in the Nation and twice the national average. Within the District, disparities among various groups were also evident, with an 8-year lower average life expectancy for black District residents compared to white District residents.

High Costs of Premiums and Low Rates of Coverage Plague Consumers, Employers and Providers

Nearly 25 percent of District residents are uninsured. This compares to a national average of 14 percent and a figure in neighboring States of roughly 12 percent. Seventy percent of Hispanics residing in the District are reported to be without health insurance coverage. Per capita health expenditures in the District are the eighth highest in the Nation, $2,548 per capita in 1990. The total District health care bill is anticipated to more than double by the year 2000.

One of the most striking facts highlighted at the hearing was the degree to which health care services in the District are paid by government sources. Nationally, 19 percent of health care costs are covered by medicaid and other public programs (not including medicare.) In the District, the comparable figure for public expenditures is 39 percent—double the national average. When medicare is included, direct government expenditures for the health care of District residents rise to 61 percent. This compares to a national average of 38 percent. As employers, the District and Federal governments pay for the health care coverage of additional District residents. Up to one-third of District residents secure their health insurance through government sources because of their status as government employees or dependents of government employees. As a percentage of annual health care expenditures in the District, this represents another 14 percent of spending. Directly or indirectly, government sources cover roughly three-quarters of all health care expenditures in the District.

Hidden within this total of government expenditures is the cost of treating the uninsured. According to hearing testimony, a typical uninsured individual generates roughly 70 percent of the health care costs as does someone with health insurance. While the uninsured cause fewer billings than do the insured, the average uninsured individual reimburses providers for only one-third of expenses generated. Government programs and facilities, and cost shifting to the premiums of those with insurance, absorb the remaining charges.

Testimony from Georgetown University Medical Center acting administrator, Henry McQueeney, illustrated the prevalence of

"cost-shifting," that is, the passing along to other parties the costs of "uncompensated care." Asked to provide an estimate of the effect on charges if uncompensated/charity care and bad debt were eliminated through the implementation of universal coverage and single payer rates, Mr. McQueeney responded, "Georgetown would be able to reduce its current charges by approximately 35 percent . . ."

Some Health Reform Proposals Could Exacerbate Problems with Access to Care

The maldistribution of primary care providers in the District poses serious concern. Overall, the number of primary care providers per capita is twice the national average. However, these providers are concentrated primarily in the more affluent sections of the District. Southeast Washington and other parts of the city lack adequate numbers of health care professionals. Less than 10 percent of the primary care physicians enrolled to provide care to medicaid beneficiaries are located in southeast Washington, where more than 50 percent of the District's medicaid recipients live. Over two-thirds of the primary care physicians enrolled to serve medicaid recipients in the District are located in northwest Washington, where slightly more than 20 percent of the District's medicaid recipients reside.

Hearing testimony suggested that barriers to access may be exacerbated under certain health insurance reform proposals. Comparing health plans with an open-panel of providers to those with closed-panels, and comparing plans serving nonmedicaid populations to those primarily serving medicaid recipients, demonstrates great differences in the ratio of primary care providers to plan enrollees. For example, while southeast Washington suffers from a lack of primary care providers, medicaid recipients enrolled in one medicaid-predominant prepaid health plan have access to only a fraction (7 percent) of the already limited number of medicaid providers in their area. While fewer participating physicians in a plan may not directly translate to limited access to care, evidence suggested that barriers to care are significant.

A memorandum from the D.C. Commissioner of Public Health to the administrator of the Ambulatory Health Care Administration (AHCA) identified "in excess of 3,000 visits at AHCA facilities to medicaid recipients who are enrollees of the Chartered Health Plan, HMO." In an attached letter submitted for the hearing record from the Doctors Council to the commissioner of the District's Health Care Financing Commission, the following findings were reported:

"There appears to be a number of reasons for the return to the [District Public Health Commission] clinics of a significant number of Chartered Health patients. Among most frequently stated reasons are accessibility of the [neighborhood health clinic]; preference for clinic provider; an inability to timely schedule with a Chartered Health provider; and an inability to formally disenroll due to confusion regarding the disenrollment process."

The receipt of care at public facilities by medicaid beneficiaries who are enrolled in a prepaid health plan not only signifies possi-

ble barriers to access but also represents an inefficient expenditure of health care resources, in effect paying twice for the same service.

Testimony from a national insurance carrier illustrated the problems medicaid enrollees have in gaining access to large numbers of health care providers. In written testimony, the Prudential Insurance Company of America stated that it "strongly supports the managed competition approach to meeting the health care needs of District of Columbia residents," and went on to say that Prudential has chosen not to participate in the current D.C. medicaid prepaid option because, in part, "The District requires that, if an HMO serves medicaid recipients, all the HMO's providers must serve medicaid recipients in all their offices. We knew that some of our providers . . . would drop out of our network if we required them to serve medicaid recipients. Rather than jeopardize our provider network, we elected not to participate. Maryland has no such requirement, but allows us to designate a provider network for medicaid . . ."

Some reform initiatives could lock these barriers in place by segmenting medicaid beneficiaries from the general population.

Ramifications of Universal Health Insurance Coverage in the District

A survey conducted by Lewin-VHI, Inc. for the D.C. Hospital Association illustrated that the health status of residents could be improved and health care expenditures potentially reduced if access to basic health care services was improved. Lewin-VHI Vice President John Shiels testified at the hearing that results of the 1988 survey indicate that 40 percent of the uninsured individuals utilizing D.C. hospitals were being treated for "medically avoidable" conditions. These are medical problems that could have been avoided if they had received timely and appropriate primary care. A similar percentage of the uninsured patients said they had problems accessing primary health care. These medically preventable admissions were most concentrated in the lowest income areas of the city.

Health insurance reform—depending upon the particulars of the reform ultimately enacted—has the potential to either alleviate or exacerbate current problems with access to care and cost of insurance coverage. For the residents of the District of Columbia, cost shifting and cost spiraling could be reduced, access to high quality care could be increased, and coordination and efficiencies could be improved. Conversely, access to care could be further restricted, the oversupply and concentration of facilities may be perpetuated, and the escalations in cost could continue unchecked. In his statement for the hearing record, Representative Thomas Bliley contended that regardless of the form that health reform takes, universal access to health insurance coverage will not automatically eliminate the barriers to care and the differences in health status among segments of District residents.

Representative Eleanor Holmes Norton communicated the interests of District officials in developing a model health reform program for the District of Columbia. She also reported the results of

a survey conducted by her office showing that "a great majority of residents of the District of Columbia are for a single-payer plan."

HEARING ON HEALTH REFORM

Monday, April 19, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE DISTRICT OF COLUMBIA,
Washington, DC.

The committee met, pursuant to call, at 10:05 a.m., in room 1310-A, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the committee) presiding.

Present: Representatives Stark, McDermott, Norton, and Lewis.

Majority staff present: Broderick D. Johnson, staff director; Dietra L. Ford, senior legislative associate; Joan V. Middleton, administrative officer; Marvin R. Eason, and Rene Carter, staff assistants; and Doneg McDonough of Mr. Pete Stark's staff.

Minority staff present: Dennis G. Smith, staff director; and Rick Dykema, staff assistant.

William G. Wren, GPO publication specialist.

The CHAIRMAN. Good morning.

The Committee on the District of Columbia will begin a hearing this morning on the coverage and access of health insurance in the District of Columbia, and we hope that this discussion will help us in the national debate.

We would like to focus on the implications for the District residents in relation to cost and access under various national plans that are being considered. The District of Columbia, like other urban centers, has serious health insurance coverage and access problems and some more severe than the national averages might suggest. Fourteen percent of the national population has no health insurance coverage, and in the District we think it is closer to 25 percent of the residents being uninsured.

Also, I would like to make just a definitional statement in that in my lexicon there are coverage and access; I think it is important that we make the distinction. Many of us may have coverage and no access; no access because we live in a rural community; no access because we have medicaid coverage and the provider will not take us; there is a variety of things. Many of us may have access. We all do by law because it is against the law to turn somebody away from an emergency room, but you still may not have coverage to protect you from the financial disaster, if that is the way you choose to enter the health care system.

The reasons we are holding this hearing are to identify mechanisms that would improve both access and coverage to care, and, of course, nationally the topic is to restrain health care costs.

I guess also at the onset of this, I would like to suggest that this hearing is not a precursor of this committee beginning to tell the

District of Columbia government how to run their show—I think it is important that we state that at the onset—any more than the Federal Government may, in fact, set down standards for the 50 States and territories if, in fact, that is the result of Federal health reform.

It is, however, too often that we don't look beyond our own neighborhoods and our own experience to find out what problems do exist. It appears to me that we have an opportunity here to learn first hand how a variety of proposed solutions to what is referred to as the problem, the problem being access and coverage denied, and the other side of that problem is costs escalating at 12 to 15 percent a year when we are in an area of flat or very little inflation, which will soon drive the economy into complete disaster if we don't control that.

We intend to hear this morning from the members of the Government, providers and insurers, and we are going to attempt to answer two questions: One, what is the level of coverage in the current system; and, two, what would be the result of applying a variety of options or a variety of solutions to hold down costs and provide coverage. How much of that information we will feel comfortable with when we end the hearing remains to be seen, but I look forward with some enthusiasm to hearing what our witnesses will tell us this morning and to begin to get into focus the impact on this community—to which whatever reform is decided in the White House; how it will apply here and how it will work.

[The prepared statement of the chairman with attachment follows:]

OPENING STATEMENT

THE HONORABLE PETE STARK
CHAIRMAN
COMMITTEE ON THE DISTRICT OF COLUMBIA

APRIL 19, 1993

Good morning. Today, the Committee will hear testimony concerning health insurance reform in the District of Columbia, and through this contribute to the national debate. Our attention will focus on the implications for District residents in relation to cost and access under various national health reform options.

The District of Columbia, like other urban centers, has serious health insurance and access problems, problems more severe than simple national averages suggest. Nationally, fourteen percent of the population has no health insurance coverage. In the District, some twenty-four percent of residents are uninsured. Another eighteen percent are on Medicaid.

The objectives of insurance reform -- the reasons why we are holding this hearing -- I hope, are to identify the mechanisms to improve access to care and restrain the growth in health care costs. What we are striving for is to improve the health status of all segments in our society. Indicators such as life expectancy differentials and infant mortality rates highlight the health deficit the District is facing. In the District, there is an almost eight year difference in average life expectancy between Blacks and whites. The infant mortality rate in the District, at 21 deaths per thousand, is the highest in the country, is more than double the rate for all Americans, and is 18% higher than the average for Blacks nationwide.

In terms of the costs of health care and the burden it places on the average family, I hope that we all agree that controlling health care costs must be a central element of any reform package. Taking the total amount of spending on health care and comparing that against the median family income, we can determine the number of days of a family's earnings it takes to pay for health care costs. In 1980, it took 30 days. By 1991, it took 44 days -- an increase of fifty percent. If the trend is allowed to continue, by 2002 it will take a family at the median income an average of more than two months -- 64 days -- to cover the costs of health care. This is simply not sustainable if families are to meet all their basic needs.

The agenda for today's hearing is to first get an idea of the current level of coverage and cost of health insurance in the District. Who is covered? Who isn't? Who provides the care? Who pays for the care of the uninsured? Where are the providers located? Where are they in relation to the residents?

Once the groundwork has been laid, we will call upon a series of witnesses to comment on the implications for District residents of various national health insurance reform options. A panel of insurers -- commercial carriers and HMOs -- which are currently writing policies in the District of Columbia, a panel of District hospital representatives, and a number of provider organizations will field questions and help illuminate what these implications may be.

While the hearing will focus specifically on the District of Columbia, the information gathered from this hearing will be useful to various States as they consider how these health insurance reform proposals might be implemented in their jurisdictions.

As you are aware, there are numerous proposals to reform the United States health insurance system. In this hearing, we will consider three of these. These are a managed competition plan, a single payer model, and a pay-or-play proposal with a Medicare-for-all type plan as the public plan option.

All of the witnesses participating today have received summaries of these health reform options. We have also placed summaries of these three options on the table in the back of the committee room.

CHARACTERISTICS OF THREE HEALTH REFORM OPTIONS

Characteristics Common to All Three Options:

Eligibility: Universal; guaranteed renewability
Financing: Some combination of employer, individual, and/or government financing
Benefits: Medicare benefit package, plus pharmaceutical, pre-natal and well baby care

	COVERAGE	ENROLLMENT	PRE-EXISTING CONDITION EXCLUSIONS	CHOICE OF PROVIDERS	PREMIUM RATES	MEDICAID	MEDICARE	PROVIDER REIMBURSE-MENT
OPTION 1: MANAGED COMPETITION	Insurance required to be purchased through a regional purchasing cooperative (potential opt-out for employers w/ 1000+ employees)	Annual open enrollment period	None allowed	Limited to providers associated with plans approved by the HIPC	Single premium rate to be set for each insurance plan and would apply to all plan enrollees	Government support set at the amount of the lowest cost plan; insurance coverage secured through HIPC	Continue as is, with additional pharmaceutical and preventive care benefits	Emphasis on capitated reimbursement with some continuation of current mix
OPTION 2: ALL-PAYER PAY-OR-PLAY	Employers/ individuals purchase insurance through private insurance or through a Medicare-type public plan; supplemental policies available	Continuous open enrollment	No exclusions allowed for those changing jobs with less than a 3 month break in coverage; otherwise, six month limit on exclusion period	Free choice of providers, including freedom of choice for low-income recipients	Private plans could set community rates for individuals and groups separately; public plan premium would be set at actuarial value	Incorporated into Medicare-type plan	Continue as is, with additional pharmaceutical and preventive care benefits	Use of all payer rates based upon current average private sector rates with adjustment of rates using Medicare-type mechanisms; rates subject to rate of growth limits under a national budget
OPTION 3: SINGLE PAYER MEDICARE -FOR- All	All residents to purchase core benefit package through Medicare-type plan; supplemental insurance policies available	Continuous open enrollment	None allowed	Free choice of providers, including freedom of choice for low-income recipients	Premium set at actuarial value of the plan	Incorporated into Medicare-type plan	Continue as is, with additional pharmaceutical and preventive care benefits	Use of Medicare reimbursement mechanisms and rates; rates subject to rate of growth limits under a national budget

The CHAIRMAN. Mrs. Norton.

Ms. NORTON. Thank you, Mr. Chairman.

Mr. Chairman, far from regarding this as a home-rule issue, it is for us, welcome to have your special attention to the District of Columbia on health care. This is not a home-rule issue, this is a national issue, and health care can be solved only through national legislation. We especially welcome it in the District of Columbia where we are fifth from the bottom in health insurance coverage, and yet we have some of the Nation's great teaching hospitals, we have Howard University, which, along with Meharry, has trained a disproportionate share of the African American doctors in this country, yet this city has a hospital crisis and a health care crisis that is reminiscent of the other large cities of the country.

I must tell you, Mr. Chairman, that last January, or January 1992, along with Members from across the country, I had a standing-room-only town meeting on health care where the interest in health care was across the board from providers to citizens who waited in line hours simply to say a few words on health care and the needs in this city.

I did a survey which showed that the great majority of the residents of the District of Columbia are for a single-payer plan. Mr. Chairman, you indicated an interest in perhaps at some point, a model program of some sort for the District of Columbia. I want to assure you that is something that I am sure the officials of the District of Columbia would want to explore.

The District of Columbia is a perfect laboratory for such exploration. It is a large city, and yet it is a manageable one. It is the most visible city in the United States. So, if we, in fact, move as a Nation on health care beginning here, we send a message to other large cities on this vital issue.

Indeed, I have a letter that memorializes a conversation I have had with President Clinton asking him to regard the District of Columbia as a model city for his own programs. There could be none more important to begin with than health care.

I therefore wish to thank you for the first indication that the District could be looked at as a special case that might, with what we do with health care here, be used in cities and communities around the country.

Thank you very much, Mr. Chairman.

The CHAIRMAN. I thank the gentlewoman for her contribution.

Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I simply want to say that, you always have to ask yourself, why does somebody from Seattle get on the District Committee? I was interested in getting on this committee because I always thought that Washington, DC., was a perfect laboratory for demonstrating what needed to happen in this country in terms of health care. All the problems of major cities are here, and it is in a small, confined area where we could actually, I think, put together a very useful health-care plan.

I am additionally concerned as I watch what is happening in terms of jobs in this country. Last month, the Labor Department indicated about 200,000 more jobs were created in this country, most of them part-time. Now part-time jobs, by and large, do not

have benefits attached to them, and the problems of the cities of this country, including Washington, DC., are going to be compounded by this change in the job market.

Some have suggested that people are going to part-time jobs essentially to avoid giving benefits, and if that be true this problem is going to spread across the country in ways, I think, that we have not considered.

So, I think it is very timely that you are having these hearings. I want to do everything I can to help use this as a means to demonstrate what the real problems of the American people are in dealing with the health care system.

Thank you.

The CHAIRMAN. Thank you.

Before we turn to our first panel, I would like to inform the Members and the witnesses that the record will remain open for 5 business days after our hearing today to allow witnesses wishing to submit additional comments or indeed, to allow Members to submit written questions to some of the witnesses and let them provide additional data.

Finally, I would like to alert Members to the fact that we will break at noon for an hour and continue to finish the panel and the questioning this afternoon. I would also like to acknowledge that Representative Bliley had planned to be here and was unavoidably detained and will have material, which we will, without objection, include in the record.

[The prepared statement of Mr. Bliley follows:]

THOMAS J. BLILEY, JR.
3d DISTRICT, VIRGINIA

MEMBER OF
COMMITTEE ON ENERGY
AND COMMERCE
COMMITTEE ON THE DISTRICT
OF COLUMBIA

Congress of the United States
House of Representatives
Washington, DC 20515

WASHINGTON OFFICE
224 RAYBURN OFFICE BUILDING
(202) 225-2815

DISTRICT OFFICE
SUITE 101
4914 FITZHUGH AVENUE
RICHMOND, VA 23230
(804) 771-2809

Statement of

Rep. Thomas J. Bliley, Jr.

Impact of Health Care Reform on District Residents

April 19, 1993

Peter Drucker, one of the foremost authorities on management in modern times, once wrote, "the most common source of mistakes in management decisions is the emphasis on finding the right answer rather than the right question." There is both a great deal of wealth and a great deal of poverty in the District of Columbia. Workers here receive one of the highest average salaries in the nation. Yet, it is estimated that a third of District residents either rely on Medicaid for their health insurance or have no insurance at all. This disparity invites many questions. For both the District and the nation, there are indeed many questions which need to be asked before embarking on the path to health care reform. I anticipate that today's hearing will be most helpful if we heed Mr. Drucker's advice.

It is important to fully address the same questions which have remained unanswered since the mid-1970s: What is the purpose of national health care reform? Is the purpose to control health care costs? If so, are you willing to deny medical care to yourself or someone else in order to control costs? Is it to provide necessary medical care to individuals whose lives are endangered because they do not receive the care they need? If so, what are the reasons people do not currently participate in the vast health care delivery system? The reasons for non-participation clearly have policy implications. We know, for example, that maternal drug abuse

has had a profound impact on the infant mortality rate here in the District. Will a switch to a national single-payor really change that?

We also should ask, why, despite the many resources present in the District, do not all pregnant women from low-income families receive the services they need? I believe that the fragmented, complex public health service delivery system which Congress has established here and across the country is in part to blame. The public health system is stuck in outdated management theories. Whether intentional or not, the federal government has tried to manufacture healthy children by using the same scientific management model as it used to build bombers in World War II. That is, it broke the service system down into separate categorical programs among program specialists. That is why, in part, women and children travel all over the District to obtain prenatal care from one provider, WIC services from another, and family planning services from yet another. We tend to measure the process rather than what really matters, which is individual client outcomes. For example, despite the presence of significant Hispanic and Asian populations, rice has not been an approved food under the WIC program in the District. Federal regulations simply discourage innovation.

Case management may simply be an expensive Band-Aid to fix a problem created by the fragmented public health system. I have been a strong advocate of one-stop shopping, especially for maternal and child health care, but we need to go further in restructuring how public health services are delivered. More than ever, we need to challenge the wasteful bureaucracy which consumes much of the resources meant to serve people.

Is the purpose of health care reform to shift public subsidies to redress perceived inequities between groups whether they may be of different incomes, employment experiences,

or generations? If so, must the entire health care system be changed to accomplish the social welfare goals and what are the unintended consequences? We know, for example that children living with only one parent are twice as likely to be without health insurance as children in two-parent families. Will we somehow encourage an increase in single-parent families? Homicide kills half of the District's youths who are between the ages of 15 and 24. Can a change in how the health care bills are paid really change that tragedy?

The combinations and permutations of each of these questions are nearly endless. It is therefore critical to know exactly where change will take us before we go. For example, the question of cost control requires us to ask, what is driving up health care costs? Its always popular to try to finger a villain to punish, but this tactic rarely solves the problem.

At the moment, it is fashionable to blame the pharmaceutical industry and the use of expensive new technologies for our health care financing woes. But the truth of the matter is that savings as well as costs are shared among health care components, the people who use them, and third party payors. New technologies, including new drugs, are expensive at first, but generally effect savings in the long-term as they become accessible to more people. Few lives were saved twenty years ago when heart surgery was still relatively new. But technology has made surgery both safer and less expensive.

Consider for example that cardiac catheterization was the second most frequently performed surgical procedure in 1990. There are now more coronary bypass procedures performed than appendectomies performed each year. On the other hand, the fastest growing Medicaid expenditures are not "high tech," but rather are found in the labor intensive services of home health care and intermediate care facilities for the developmentally disabled.

The discussion of health care reform nearly always starts with how much Americans spend on health care, but seldom includes how much we value it. A value assessment requires that comparisons be made. For example, personal consumption expenditures for health care costs increased 130 percent in constant dollars between 1970 and 1990. The rising costs are alarming, but how do we decide whether we spend too much? In 1990, Americans spent nearly twice as much on new automobiles than they did for the life-saving drugs now available. We spend less on hospitals and nursing homes than we do on clothing, accessories, and jewelry. Americans spend more on dining out and on household utilities than on physician services. Does the rate of increase in medical costs justify federal takeover of the health care profession? If so, the entertainment industry and lawyers better watch out. Expenditures on radios, televisions, records, and musical instruments increased by nearly 500 percent in constant dollars between 1970 and 1990. The increase in legal services expenditures is 91 percent compared to the 105 percent increase for physician services for this period. The issue is not that health care costs will continue to increase, but rather, how we measure the value of care. The central issue of health care reform is, should government, rather than the individual, assess the value of health care against the cost of it and control access to the care we want for ourselves and our families?

Congress and the President are at grave risk of repeating the mistake of the Medicare catastrophic insurance "reform" of the 1980s. The lesson of that debacle is that the people who will pay for the cost of reform must receive a proportionate benefit. Workers and their families will always ultimately pay the health care bill whether in higher taxes, higher premiums, higher health care costs, and/or in lower wages. Working families do not pay just for their own care,

but also for those who cannot afford medical services. Before government takes at least another $90 billion out of their pockets for health care reform, working families have the right to know what real benefits they will receive in return and to demand that the federal government reduce its own administrative costs and the costs it forces onto state and local governments first.

One thing that is clear about health care reform is that however the costs are shifted among households, government, and business, working families have to pay for all of the promises we make to the American people.

The CHAIRMAN. I would now like to also suggest to our witnesses today that we are going to play with this new machine here in an attempt to keep all of us—the chairman needs it more than anyone—to some kind of a time limit so we can have a lot of time for questions. We will and do have your prepared testimony, and I think there will be a lot of additional information that Members would like to develop in their inquiries. So, I hope you will bear with us. Nothing untoward—your seats are not wired, so nothing serious happens if we run over, but it will just help us all to move along and give everybody an opportunity to inquire.

With that rather foreboding welcome, I would like to introduce our first panel consisting of David Coronado, who is the acting commissioner for the District of Columbia Commission on Health Care Finance. He shares the limelight with John Shiels, who is a vice-president of Lewin/VHI. These are people who are in the nature of rocket scientists and crunch all kinds of numbers and give us all kinds of information which those of us who wander in the health care arena are often amazed by, and sometimes disappointed and pleased by.

So, if we could have Mr. Coronado and Mr. Shiels come up to the witness stand, we will proceed. Welcome, gentlemen. We appreciate your joining us this morning. Why don't we start off with Mr. Coronado.

If you would like to expand on your testimony or enlighten us in any way you are comfortable, please proceed.

STATEMENTS OF DAVID CORONADO, ACTING COMMISSIONER, DISTRICT OF COLUMBIA COMMISSION ON HEALTH CARE FINANCE; AND JOHN SHIELS, VICE-PRESIDENT, LEWIN/VHI

STATEMENT OF DAVID CORONADO

Mr. CORONADO. Chairman Stark, members of the committee, I am pleased to have been given the opportunity to appear here before you today to address this hearing on health care reform and the implications for residents of the District of Columbia.

The District of Columbia, like other States around the country, is struggling with the cost of the commitment that it has made to provide or provide for, the health care of its most vulnerable citizens. Between fiscal year 1988 and fiscal year 1992, the District saw the cost of its medicaid program increase by some 37 percent, growing from $375 million in 1988 to $593 in fiscal year 1992.

I have included a graph that demonstrates the increase in the program's expenditures over the period as attachment 1 in your packet. At the same time, the number of clients served by the program increased by 8.9 percent, from 96,000 in 1988 to 106,000 in 1992, with most of that growth occurring in the last 2 years of the period. The growth in the number of eligibles is demonstrated in the graphic that is included as attachment 2.

The District has a long and well known history of generous support for health care programs for the most vulnerable of its citizens. However, cost increases of the magnitude mentioned here have caused the District to reevaluate its support, not reevaluate it with an eye toward reducing either the number of citizens for whom it provides coverage or the scope of the services covered but,

rather, with an eye toward ensuring that the services provided are appropriate and that they are provided in as effective and, of course, economical a manner as is possible.

Consequently, we have been introducing measures of our own to control costs and to improve access. For example, I have a copy of a press release that I would like to have entered into the record later from Mayor Kelly that speaks of two task forces that have been created to improve our public health care system in the District.

We have also started developing a plan of managed care for our AFDC and AFDC-related recipients, and we are also reforming the payment methodologies for our institutional providers in the medicaid program. In addition, we have also been studying the health care reform plans of other States and the national plans as well, looking for an approach that best suits our needs, and we were very pleased to have received this opportunity to participate in this discussion of the three health care proposals under consideration by this committee.

In fiscal year 1992, 106,000 of the District's 589,000 residents were covered by medicaid. That is approximately 18 percent. We are forecasting that this number will increase to 112,000 in fiscal year 1993. Medicaid recipients live in all of the District's eight wards. However, given the income-related nature of eligibility, the greatest number live in wards 7 and 8, which have the lowest per capita income level among all wards, and the fewest in ward 3, which has the highest per capita income. The specific number as of January of this year by ward are 12,947 in ward 1; 11,485 in ward 2; 989 in ward 3; 8,016 in ward 4; 14,423 in ward 5; 12,609 in ward 6; 17,774 in ward 7; and 24,180 in ward 8. I have included a table that shows the distribution of medicaid families and individual recipients by ward as attachment 3.

The District's medicaid program has over 13,000 enrolled providers, including hospitals, physicians, dentists, nursing facilities, durable medical equipment providers, and almost every other type of health care provider there is. Included in that number are 7,219 enrolled physician providers, of whom 1,843 are in primary care specialties.

In addition, we are also fortunate enough to have 16 ambulatory health care centers operated by the District's Commission for Public Health enrolled as providers. These public health clinics are scattered throughout the city and really serve as the only city-wide network of health care providers that we have for medicaid.

Medicaid's institutional providers are located throughout the city. Although their distribution is not ideal, I would say that they are well enough distributed so as not to pose a major access problem for medicaid clients. However, I cannot make that statement about physician providers, particularly those in primary care specialties.

I have attached two tables that should give you a clear picture of where the primary care physicians are in relation to the consumers. The first is attachment 3, which we spoke of earlier, and that is the table that shows the distribution of medicaid recipients by ward. The second, which is included as attachment 4, is a table that shows the distribution of primary care providers, including physicians, enrolled in the medicaid program by location.

As is demonstrated in the two tables, over two-thirds of the primary care physicians practicing in the District are located in wards 1 and 2, where slightly over 20 percent of the District's medicaid recipients live, while less than 10 percent of the enrolled primary care physicians are located in wards 6, 7, and 8, where just over 50 percent of the District's medicaid recipients live.

We are concerned here in the District about ensuring access for our most vulnerable residents, and we are doing what we can at the moment to improve the health care system. We have taken steps, we do intend to take further steps, and we welcome the opportunity to work with this committee with any plans that it might have.

Thank you. If you have any questions, I would be happy to answer them.

[The prepared statement of Mr. Coronado with attachments follows:]

Testimony of David Coronado
Presented To The House Committee on the District of Columbia
April 19, 1993

Chairman Stark, members of the Committee, I am pleased to have been given the opportunity to appear here before you today to address this hearing on health care reform and the implications for residents of the District of Columbia. The questions my fellow panelists and I were asked to address this morning center around two major topics, the current state of insurance coverage among D.C. residents and the distribution of providers and how both might affect health care reform. The Commission that I head is responsible for administering the District's health care financing programs, including the Medicaid program and two state funded programs for residents who are not eligible for the Medicaid program. While these programs are not insurance in the classical sense, they do provide for the health care needs of a significant portion of the District's population.

The District of Columbia, like other states around the country, is struggling with the cost of the commitment it has made to provide, or provide for, the health care of its most vulnerable citizens. Between fiscal year (FY) 1988 and fiscal year 1992 the District saw the cost of its Medicaid program increase by some 37 percent, growing from $375 million in FY 1988 to $593 million in FY 1992. I have included a graphic that demonstrates the increase in the program's expenditures over the period as Attachment I. At the same time, the number of clients served by the program increased by 8.9 percent, from 96,976 in 1988 to 106,124 in 1992, with most of that growth occurring in the last two years in the period. The growth in the number of eligibles in demonstrated in the graphic that is included as Attachment II.

The District has a long and well known history of generous support for health care programs for the most vulnerable of its citizens. However, cost increases of the magnitude mentioned here have caused the District to re-evaluate this support. Not with an eye toward reducing either the number of citizens for whom it provides coverage, or the scope of the services covered, but rather with an eye toward ensuring that the services provided are appropriate and that they are provided in as economical and effective a manner as possible. Consequently, we have been introducing measures of our own to control costs and improve access. In addition, we have also been studying the health care reform plans of other states, and the national plans as well, looking for an approach that best suits the District's needs and were pleased to receive this opportunity to participate in this discussion of the three health care proposals under consideration by this Committee.

With this in mind I have taken the liberty of answering the questions that I understood would be asked by the Committee in the order in which they were presented. The questions, and my answers to them follow.

HEALTH INSURANCE COVERAGE

WHO HAS INSURANCE, THROUGH WHOM, AND AT WHAT COST? In FY 1992 106,142 of the Districts 589,000 residents were covered by Medicaid. We are forecasting that this number will increase to 112,000 in FY 1993. An additional 1,000 plus were covered by the District's Medical Charities program and the Insurance Program for Persons with AIDS. In FY 1992 the District spent $593 million for services provided to Medicaid recipients. In FY 1993 we are expecting to keep program expenditure at last year's level.

WHO DOESN'T HAVE INSURANCE, HOW DO THEY GET HEALTH CARE, AND HOW IS IT PAID FOR? Eligibility for Medicaid is income and category related. In other words, to become eligible it is not enough that one is poor. An applicant must also belong to one of the categories included in the federal legislation governing the program. He or she must either be a member of a family receiving Aid to Families with Dependent Children (AFDC), or be aged, blind or disabled. In recent years the categories have been expanded to include low income pregnant women and children not receiving AFDC and the elderly whose incomes exceed the federal poverty level, but are below 110 percent of poverty. As a result of the categorical requirements, men between the ages of 21 and 64 and childless women in the same age bracket can seldom qualify for Medicaid, regardless of their income. In addition, the income eligibility level in the District for Medicaid is at slightly over 70 percent of the federal poverty level for most Medicaid recipients, except pregnant women and children and the elderly. This level is much higher than that of most states, but it is still low enough to eliminate all but the poorest of District residents. When those without health care coverage, whether it is insurance, Medicaid or Medicare, need health care they usually seek it late and they usually seek it in the public sector. For example, last year the Commission on Public Health's ambulatory health clinics provided over 32,042 pediatric visits; 20,415 OB/Gyn visits; 31,494 general medicine visits and many more other such services to low income persons. D.C. General, the city's public hospital, also provides a substantial amount of its services to the uninsured.

WHO ARE THE INSURERS AND HOW MANY ENROLLEES DO THEY HAVE? Again, the District provides health care coverage for most of its poor residents through the Medicaid program and two other small programs that are totally state funded, the Medical Charities program and the Insurance Program for Persons with AIDS. In FY 1992 the medicaid program paid had 106,124 enrollees, the Medical Charities program slightly over 1,000 and the Insurance Program For Persons with AIDS 43.

HOW DOES THIS VARY BY WARDS OF THE DISTRICT? Medicaid recipients live in all of the District's eight Wards. However, given the income related nature of eligibility, the greatest number live Wards VII and VIII, which have the lowest per capita income levels among all the Wards, and the fewest in Ward III, which has the highest per capita income. The specific number as of January of this year by Ward are 12,947 in Ward I; 11,485 in Ward II; 989 in Ward III; 8,016 in Ward IV; 14,423 in Ward V; 12,609 in Ward VI; 17,774 in Ward VII; and 24,180 in Ward VIII. I have included a table that shows the distribution of Medicaid families and individual recipients by Ward as Attachment III.

HOW HAVE THE PREMIUM RATES CHANGED? None of the beneficiaries of the District's three health care financing programs are charged a premium for the benefits they receive.

HEALTH CARE PROVIDERS

HOW MANY PROVIDERS ARE THERE? The District's medicaid program has over 13,000 enrolled providers, including hospitals, physicians, dentists, nursing facilities durable medical equipment providers, and almost every other type of health care provider imaginable. Included in that number are 568 hospitals, 15 of which are in the District; 71 nursing facilities, 16 of which are in the District; and, 118 Intermediate care Facilities for the Mentally Retarded, all of which are located in the District. The program also has 7,219 enrolled physician providers, of whom 1,843 are in primary care specialties. In addition, we also are fortunate enough to have 16 ambulatory care health centers operated by the District's Commission for Public Health enrolled as providers.

WHERE ARE THE PROVIDERS LOCATED IN RELATION TO CONSUMERS? Medicaid's institutional providers are located throughout the city. Although their distribution is not ideal, I would say they are well enough distributed throughout the city so as not to pose a major access problem for Medicaid clients. However, I cannot make that statement about physician providers, particularly those in the primary care specialties. I have attached two tables that should give you a clear picture of where the primary care physicians are in relation to the consumers. The first, Attachment III is the table that I indicated earlier shows the distribution of Medicaid recipients by Ward. The second, which is included as Attachment IV, is a table that shows the distribution of primary care providers, including physicians, enrolled in the Medicaid program by location. As is demonstrated in the two tables, over two thirds of the primary care physicians practicing in the District are located in Wards I and II, where slightly over 20 percent of the District's Medicaid recipients live, while less than 10 percent of the enrolled primary care physicians are located in Wards VI, VII and VIII, where just over 50 percent of the District's Medicaid recipients live. I would point out though, that there are other Medicaid primary care providers who also serve the Medicaid population. For example, seven (7) of the sixteen (16) ambulatory health care clinics operated by the Commission for Public Health are located in the Wards VI, VII and VIII where most Medicaid recipients live. You will also see that there is a network of clinics spread across the city, with at least one clinic located in each Ward.

IS THERE DIFFICULTY IN ACCESSING PROVIDERS FOR RESIDENTS IN CERTAIN WARDS OF THE DISTRICT? Again, in general Medicaid recipients do not have a problem accessing providers. However, if the question is directed specifically at primary care providers, I would have to say that access can be a problematic for recipients in Wards VI, VII and VIII. The Medicaid program does pay for transportation and one could argue that the city's public transportation system is well enough developed to eliminate any difficulties that a Medicaid recipient might face in getting from Ward VIII to Ward II for a medical appointment. Nevertheless, the reality is that most Medicaid recipients are mothers with small children and no car, or other means of transportation. To them a medical appointment in Ward I or II would

probably mean taking those children on a bus trip of an hour or more each way that probably involves several transfers to get to an appointment where they have to wait 30 minutes to an hour to be spend 15 minutes with a doctor. Faced with the that prospect, I would suspect that most recipients might not choose to make or keep the appointment unless they, or their child, are really ill.

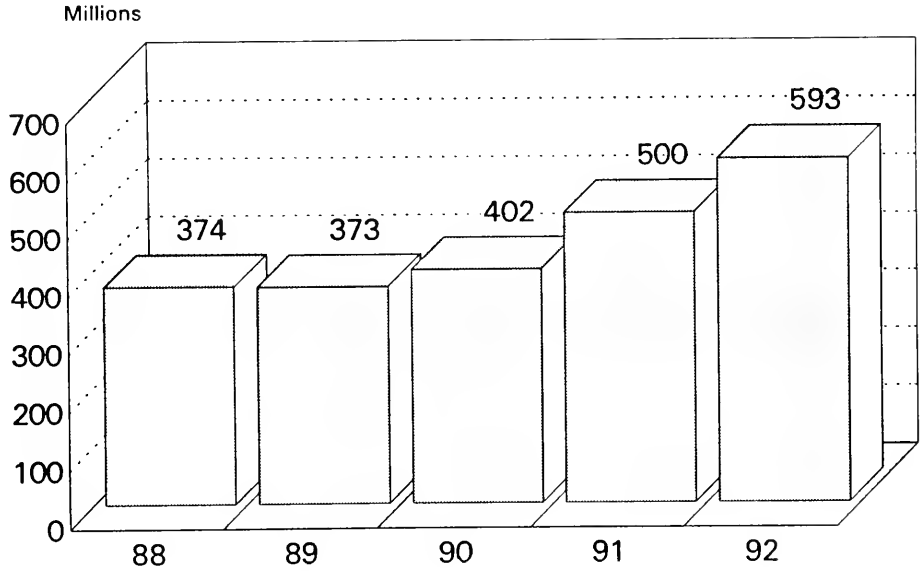
WOULD YOU SAY THERE IS A MISMATCH OF PROVIDERS IN THE CITY'S WARDS? Yes, I would say that there is a mismatch of providers in the District of Columbia.

WOULD YOU SAY THAT IF EVERYONE IN THE DISTRICT OF COLUMBIA WERE PROVIDED A MEDICARE PACKAGE OF BENEFITS TOMORROW, THAT THERE WOULD BE SOME AREAS OF THE DISTRICT WHERE PRIMARY CARE SERVICES WOULD NOT BE AVAILABLE? The experience in the Medicaid program has made it clear that having a source of payment does not necessarily guarantee access to a provider. I would suspect that at least for the short term, we would find a similar experience if a Medicare package of benefits were provided to all District residents tomorrow.

HOW MUCH MORE FINANCIAL AID WOULD BE NEEDED TO PROVIDE PRIMARY CARE SERVICES TO EVERYONE? I would hesitate to even speculate about the cost without first knowing the full extent of the benefit package and the population to whom it would be provided. However, I have estimated that it would cost the District approximately $25 million appropriated dollars to develop a sliding scale Medicaid buy-in program for pregnant women and children in families with incomes at or below 250 percent of the federal poverty level.

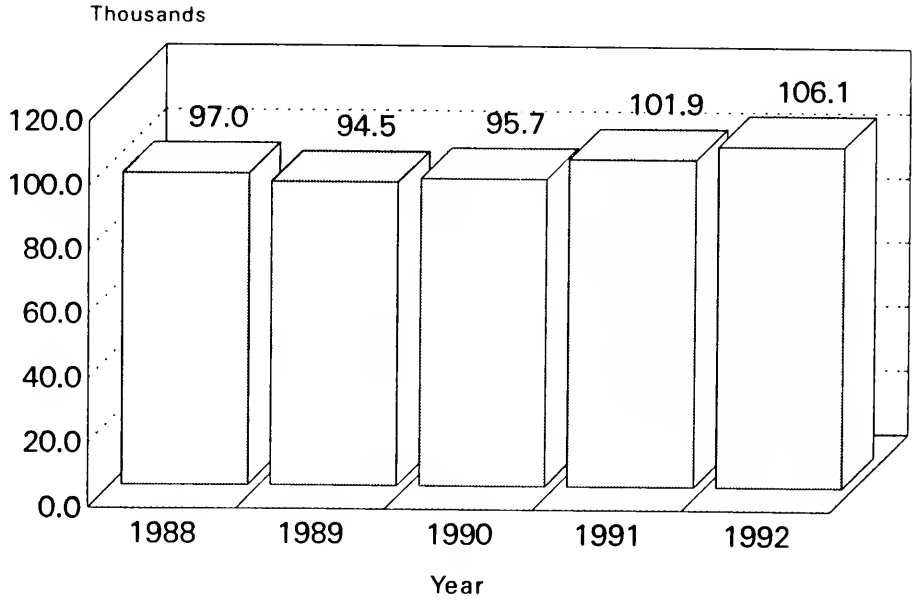
I would be pleased to answer any questions you might wish to ask.

Attachment I
Total Medicaid Expenditures
FY 1988 - 1992



Source MR 03 (Report Of Total Expenditures)

Attachment II
Total Number of Unduplicated D.C. Medicaid Clients
FY 1988 - 1992



Source: D. C. Medicaid Management Information System

Attachment III

D.C. Medicaid Recipients
By Ward
January 1993

Ward	Total Families	Total Individuals	Total AFDC	% of Total AFDC
I	7193	12947	7704	11
II	6750	11485	6370	9
III	950	989	44	0
IV	4715	8016	4564	6
V	7590	14423	9438	13
VI	7005	12609	8551	12
VII	8461	17774	13134	18
VIII	10510	24180	19057	26
Unknown	3162	6004	3722	5
Total	56336	108427	72584	

Attachment IV

D.C. Medicaid Primary Care Providers
By Location
January 1993

District Providers

Ward	Family Practice	General Medicine	Internal Medicine	Ob/Gyn	Pediatrics	CPH Clinics	FQHC	FMHC	TOTAL
I	18	176	101	21	84	2	0	0	402
II	13	321	183	66	53	3	0	1	640
III	3	9	10	7	1	1	0	0	31
IV	6	12	21	7	15	1	0	1	63
V	14	72	82	16	6	2	0	0	192
VI	4	1	8	3	7	4	0	1	28
VII	7	4	2	1	2	2	1	1	20
VIII	8	43	26	8	11	1	0	1	98
Total D.C.	73	638	433	129	179	16	1	5	1474
Maryland	31	92	66	10	55	0	0	1	255
Virginia	19	47	32	6	33	0	0	0	137
TOTAL	123	777	531	145	267	16	1	6	1866

* Primary care providers are defined for purposes of this report as physicians enrolled in Medicaid whose specialties include family medicine, general medicine, internal medicine, obstetrics/gynocology and pediatrics. The definition also includes Commission on Public Health Clinics, federally qualified health centers and free standing medical clinics.

The CHAIRMAN. Thank you.

This is an embarrassment to the Chair, but you can help me. I am looking at maps up here. Generally I know where wards 7 and 8 are, and I generally know where 1 and 2 are as I look at these teeny maps. As a practical matter, for somebody living way out Pennsylvania Avenue, say, to get to this area of 1 and 2 where all the docs are, what is involved? Quick buses? Can I get on the metro and get to where I need to go? Give me an idea.

Mr. CORONADO. Well, as a practical matter, we have to remember that most medicaid recipients are women with small children. So what usually is involved if you are coming from ward 7 or 8 is several bus rides. Generally, it is an hour or more each way, and if you consider that it involves dressing and moving small children around, then getting to a doctor's appointment, where you probably have to wait 30 to 45 minutes or maybe an hour to see the doctor for 15 minutes, it is a daunting task.

The CHAIRMAN. I understand, OK. You have two clinics, one in ward 7 and one in ward 8. So it is not like walking from here down to the Mall.

Mr. CORONADO. Not at all.

The CHAIRMAN. It is not getting on metro and going from here to the Federal Center.

Mr. CORONADO. No. Actually, it is quite difficult for some medicaid recipients to get care, particularly those who live east of the Anacostia River.

The CHAIRMAN. Why don't we go ahead, Mr. Shiels, and hear your testimony—I am sorry—and then all of us can inquire of both of you.

Thank you for the geography lesson.

STATEMENT OF JOHN SHIELS

Mr. SHIELS. Thank you. It is a pleasure to be here this morning.

In the past several years, we have done a number of studies of access in the District of Columbia for the District Hospital Association. The material that I am going to present here today summarizes some of the key findings of these several studies. Before I start, I would like to credit Ms. Ann Zvikas and Mr. John Billings for some of the very innovative work they have done in putting together this material.

There are about 530,000 residents in the District of Columbia, of whom 127,000 are uninsured. Those are the most recent figures available. Nearly 25 percent of the District population is uninsured. This compares with a national average of about 14 percent and an average of about 12 percent in the neighboring States.

The uninsured in the District are primarily nonwhite and Hispanic; 26 percent of nonwhites are uninsured, and the data reports that 70 percent of Hispanics are without insurance coverage. One in four children in the District is without insurance. In fact, nearly 30 percent of the uninsured are children.

Of course, the lack of insurance tends to track with income; 45 percent of the uninsured in the District of Columbia have incomes below one and a half times the poverty level. However, income does not appear to be the only barrier to insurance coverage; 22 percent

of the uninsured in the District report incomes of 300 percent of poverty or more.

How does the lack of insurance coverage affect access to care for the uninsured? In fact, the uninsured consume quite a bit of health care resources in this city. Total spending for health services in 1990 for District residents we estimate to be about $1.5 billion. That is total spending from all sources; 18 percent of that is attributed to uninsured persons.

Unfortunately, the care these individuals are receiving often comes too late to avoid preventable hospital conditions—expensive, preventable hospital conditions. The care often does not come until the individual's condition has become acute and the individual appears in the emergency room. This is a great financial burden for District hospitals. Hospital uncompensated care was about $202 million in 1991. That equals about 13 percent of hospital costs.

Much of the problem is due to the lack of primary care services for the uninsured. In a survey of uninsured persons using hospital emergency rooms conducted by Lewin in 1988, 40 percent of the people interviewed—these are uninsured persons now—said they had problems obtaining primary care. Of these, 62 percent said the barrier was financial; 10 percent said they didn't know where to go for the care; and 11 percent indicated that transportation was a problem.

One in five of the uninsured who used the emergency room reported a delay in seeking treatment. About 41 percent of all non-OB and nontrauma hospital admissions in the District were for what we have termed to be medically avoidable. That is, these people were admitted for conditions that could have been avoided had they received timely and appropriate primary care—for example, people admitted for conditions related to untreated diabetes or hypertension.

These medically preventable admissions occur primarily in the lowest income areas of the city. For example, if you look at table 1 on page 10 of my testimony, 63 percent of the hospital admissions for persons in the Congress Heights area—now this excludes OB and nontrauma cases—63 percent of these cases in that area were termed medically avoidable.

If you will turn to map 1, which is on page 13 of my testimony, we have marked the five lowest income areas in the District. They include Adams Morgan, which has a very large Hispanic population; Trinidad-Ivy City area, which is in lower Northeast DC.; and the three areas across the Anacostia River. Two of these areas—the Adams Morgan area and the Anacostia area—include areas that have been designated as health profession shortage areas by the Bureau of Health Care Delivery Assistance. These are areas where there is an objective criterion used to determine whether an area has a sufficient number of physicians. Infant mortality rates is one of the factors that is taken into consideration. In fact, 15 percent of District residents live in an area that has been designated a HPSA—health profession shortage area.

But is there a shortage of physicians in the District? Strictly speaking, no. In fact, the number of providers per capita in the District—number of primary care providers per capita in the District—is actually twice the national average. The problem is more

one of a maldistribution of physicians or providers within the District.

Many physicians locate in higher income areas and serve many of the suburban populations—northern Virginia and suburban Maryland. Physicians find it difficult to locate in low-income areas first of all because there is a lot of uninsured persons who can't afford to pay for the care. Many of the individuals who live in these areas are covered under medicaid, yes, but medicaid payment rates are substantially less than in the private sector. In fact, they are up to 60 percent less.

Also, if you are going to locate in one of these areas, it is very difficult to attract populations from suburban Maryland and northern Virginia to come into these lower income areas and use facilities in those areas. So it is very difficult to round out your case load with a good payer mix if you are located in those areas.

In response to these shortages, public and private organizations have established networks of clinics throughout the city, and if you look at map 2, which is on page 14 of my testimony, it shows you the location of the—I believe there are about 23 public and private clinics located in the city. If you look closely, though, you will see that it appears that an expansion of clinic services in the areas across the Anacostia River might be the next place for us to turn our attention. One of the HPSA's is located in Anacostia, the largest one, across the river.

I was also asked to discuss the cost of health care in the District. There is an acute lack of data on these sorts of things, and we have to resort to what you have referred to as rocket science. I would refer to it as rocket art because the data is rather poor.

But based on our rocket art and what data is available, we estimate that in 1990 per capita health spending in the District was about $2,548 per person. That compares to $2,400 nationwide. I believe that is figure 10.

The District of Columbia ranks eighth highest in per capita spending by these measures when compared to the other States. Health spending in the District is projected to grow to about $6,330 by the year 2000.

The CHAIRMAN. Suppose you had to kick that up to $2,500 by a third. If you have 25 percent of the people uninsured, arguably nobody is paying for them. So if you really want to talk about what the per capita expenditure through a payment system is—let's say it is $3,000. I can't do this with my shoes and socks on.

Mr. SHIELS. In this figure, we have put a value on the care that is being provided today.

The CHAIRMAN. But in the billion and a half you gave me, if you divide that by 500,000—and, again, I have to do this just to fit my mental slide rule—I get $3,000 a head for 500,000 people. But if you are looking at what goes through the normal payment program, only 75 percent of the people are insured. So basically you could say that we are charging people, if the insurance companies come out even, with insurance $4,000, and the system is swallowing through uncompensated care and charity care—is that a fair——

Mr. SHIELS. Well, I think the real problem here—we are getting into the rocket art. In the figures I just quoted you, I left out long-term care deliberately, and I left out administrative costs.

The CHAIRMAN. There is precious little of that though.

Mr. SHIELS. Yes.

The CHAIRMAN. Is it 3,000 beds maximum?

Mr. SHIELS. These are consistently defined figures over time. That is the reason I drew on them. But I can see why for this purpose we should have used the broader definition.

The CHAIRMAN. No. I guess I am just trying to sort out the difference between somebody with health insurance or in a program—medicaid, medicare, private insurance—and then those uninsured people. They personally don't pay. The system swallows those costs and passes it on through real estate taxes or we pay for it in higher insurance costs. I was just trying to see what that would amount to.

Mr. SHIELS. I think you have made the key point. This care, it occurs, it costs, and somebody has to pay for it. The people who are paying for it, of course, are people who have insurance. The hospitals, the providers, have no choice but to pass it on to other payers in the form of higher charges.

But the relative comparisons are very important. The District of Columbia ranks eighth highest nationwide when compared to the other States in terms of per capita spending. Spending for the District in 1991 was $1.5 billion. Interestingly, 65 percent of that was paid for by public programs. This includes medicare, medicaid, and a number of public programs that are funded by the District and some other Federal programs; the Federal clinics. By comparison, nationwide, 38 percent of these health care services are paid for by public programs.

I would like to take a moment before I close to put things in perspective here. Let us remember that the District of Columbia is primarily an urban center. Many of the other States that we have compared the figures to here have suburban populations, they have a mix of populations. Many of the higher income people who make their living in the District, of course, live outside of the District.

So the figures here may be making—because we are looking at just an urban center, they may make the District of Columbia look a little worse, according to a number of these standards, than we really should conclude here. In fact, the District of Columbia, unfortunately, is probably fairly typical of many major urban centers around the country.

I want to thank you for inviting me today, and it is a pleasure to testify before you again, Mr. Chairman.

[The prepared statement of Mr. Shiels with attachments follows:]

INSURANCE COVERAGE AND HEALTH SPENDING IN THE DISTRICT OF COLUMBIA

Testimony by

John Sheils

before the

Committee on the District of Columbia

April 19, 1993

My name is John Sheils. I am a vice president with Lewin-VHI, a Washington-based consulting firm, specializing in health care financing issues. Lewin-VHI has conducted a number of studies regarding insurance coverage and access in the District of Columbia. In particular, in a study performed jointly with Mr. John Billings, we examined the relationship between the lack of insurance coverage and hospitalizations for conditions which could have been avoided with adequate preventive care. I have been asked to provide background materials on insurance coverage and health spending in the District of Columbia. I would like to thank Ms. Michelle Snyder of Lewin-VHI who worked so hard to research these materials.

Our discussion covers:

- The characteristics of the uninsured in the District of Columbia
- Access to health services for uninsured persons in the District of Columbia
- Physician supply in the District of Columbia
- Health expenditures for insured and uninsured persons in the District
- The characteristics of workers without coverage on their job

The available data on these issues is presented below.

A. UNINSURED PERSONS IN THE DISTRICT OF COLUMBIA

The number of uninsured persons in the District of Columbia increased from 97,000 persons in 1987 to 127,000 persons in 1991 (Table 1). Today, nearly one in four (24 percent) persons living in the District is without health insurance (Figure 1). This compares with an average of 14 percent nationwide and an average of 12 percent in surrounding states (Figure 2). The percentage of persons without insurance in the District of Columbia is higher than in any of the 50 states, although it is fairly typical of many urban areas.

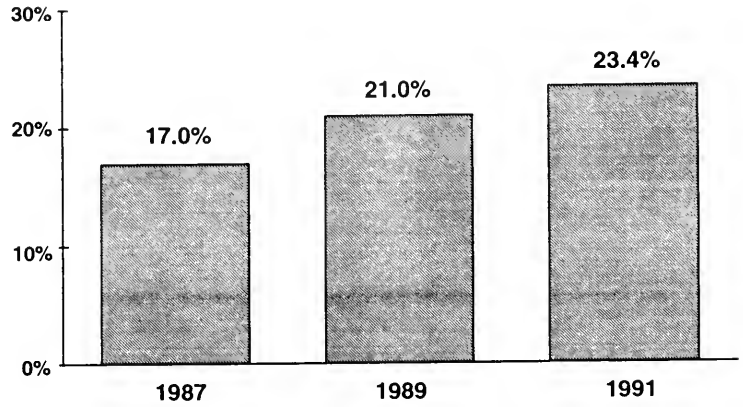
TABLE 1
PERSONS BY SOURCE OF INSURANCE IN THE DISTRICT OF COLUMBIA IN 1992

	PERSONS [in thousands]	PERCENT
TOTAL PERSONS	530	100.0%
Uninsured	127	24
Insured	403	76
EMPLOYER INSURANCE	257	48.5
Workers	156	29.4
Dependents	82	13.5
Retirees	19	3.6
Non-Group	52	9.8
CHAMPUS or Military	16	3.0
Medicaid	77	14.5
Medicare	63	11.9

[a] Numbers do not sum to total because some individuals have coverage from more than one source.

SOURCE: Lewin-VHI analysis of the District of Columbia subsample of the 1992 CPS data.

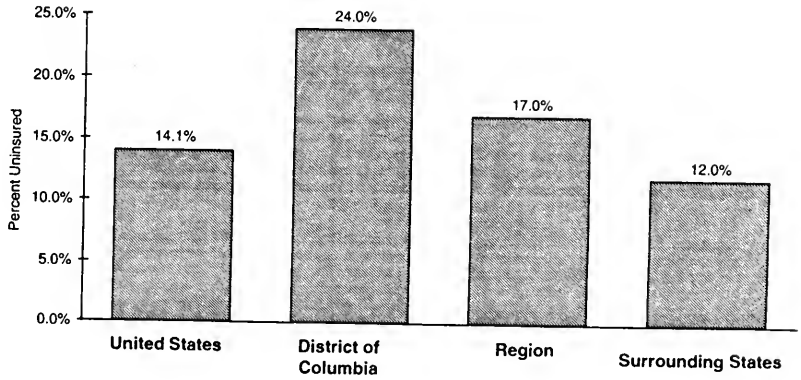
Figure 1
Percent Uninsured in the District of Columbia: 1987-1991



Source: Lewin-VHI analysis of the District of Columbia subsample of the Current Population Survey (CPS) data

Figure 2

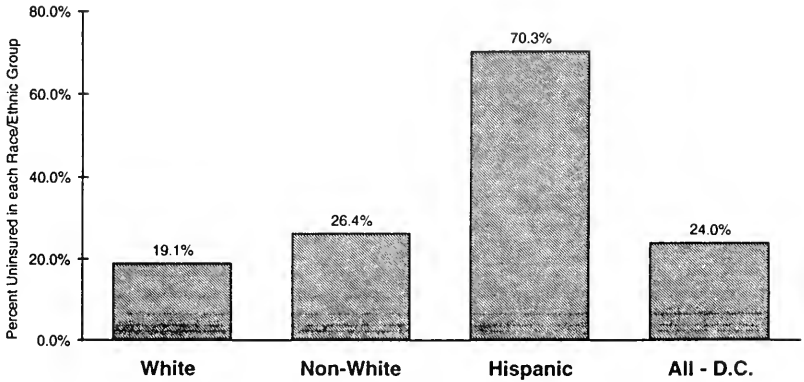
District of Columbia's Uninsured Rate is Higher than the National Average and Surrounding States



Source: Lewin-VHI analysis of the 1992 Current Population Survey (CPS) data.

Figure 3

District of Columbia's Uninsured are Disproportionately Non-White and Hispanic



Source: Lewin-VHI analysis of the Distrcit of Columbia subsample of the March 1992 Current Population Survey (CPS) data.

The uninsured in the District are disproportionately non-white and Hispanic (Figure 3). Twenty-six percent of non-whites are uninsured and 70 percent of Hispanics are uninsured (Hispanics include resident aliens).

Twenty-eight percent of all uninsured persons in the District are children under age 19. Among children under age 19, 25.6 percent are uninsured. However, the lack of insurance is greatest among young adults. Nearly 35 percent of persons aged 19 through 24 are uninsured (Figures 4 and 5).

Over one-third of the poor and non-poor (i.e., persons below 150 percent of poverty) in the District are uninsured (Figure 6). The poor and non-poor comprise about 45 percent of the uninsured population. However, income does not appear to be the only barrier to insurance coverage. For example, about 22 percent of the uninsured in the District have incomes in excess of 300 percent of poverty (Figure 7).

B. ACCESS FOR UNINSURED PERSONS

The lack of insurance has created barriers to access for primary care services and has placed an ever increasing strain on District hospitals. Many of the uninsured frequently seek and obtain all types of health care in hospitals and hospital emergency rooms, mainly because they have limited access to primary care services. This generated nearly $202 million in charity and bad debt for District hospitals in 1991. In fact, charity and bad debt were equal to about 13 percent of hospital operating costs in that year.

Figure 4
Over 25% of Children in the District of Columbia are Uninsured

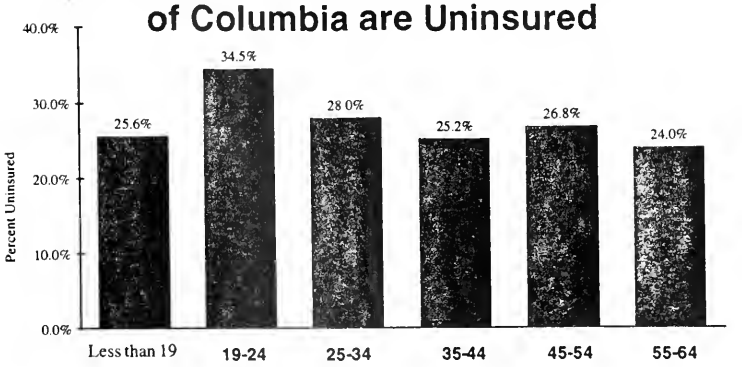
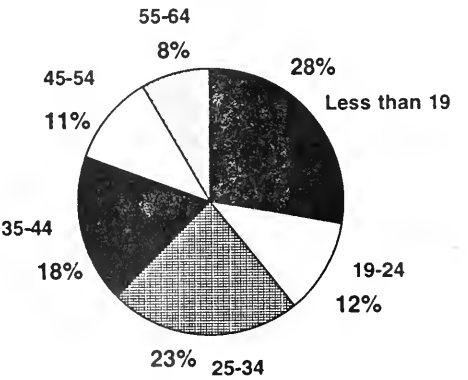


Figure 5
28 Percent of D.C.'s Uninsured are Children



Source: Lewin-VHI analysis of the District of Columbia subsample of the 1992 Current Population Survey (CPS) data.

Figure 6
Over 36 Percent of the District of Columbia's Poor are Uninsured

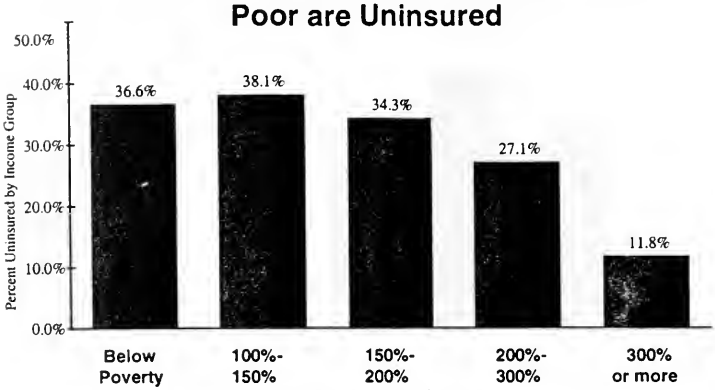
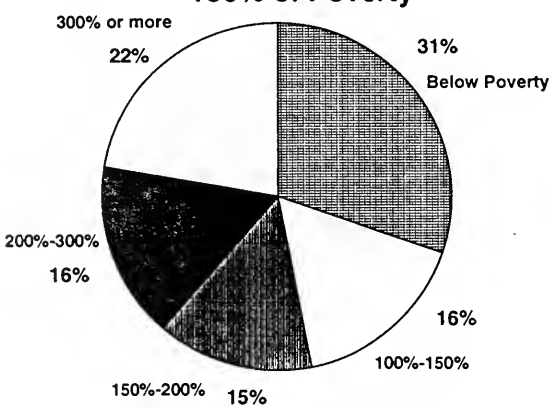


Figure 7
Over 45% of D.C.'s Poor Have Incomes Below 150% of Poverty



Source: Lewin-VHI analysis of the District of Columbia subsample of the 1992 CPS.

In a 1988 survey of uninsured persons entering District emergency rooms, about 40 percent reported having problems obtaining primary care services. Of those who report an access problem:

- 62 percent say the problem is financial;
- 18 percent say they were dissatisfied with previous care;
- 12 percent say they were not sure they needed care;
- 11 percent say they had a transportation problem; and
- 10 percent say they didn't know where to go.

About 19 percent of the uninsured admitted to hospitals, report a delay in seeking treatment (43 percent of those because of financial problems).

An analysis of hospital admission data for these patients indicates that many of them might not have needed to be hospitalized if they had had access to primary care services earlier in their illnesses. One particularly disturbing fact is that about 30 percent of all uninsured people who were admitted to hospitals during the survey period suffered from some chronic illness, such as respiratory disease, diabetes, hypertension, or alcoholism; conditions that lend themselves to management in outpatient settings. What is more disturbing is that two-thirds of these chronically ill people might have been able to prevent their hospitalizations had they found, and complied with, necessary primary care services.

About 24 percent of all uninsured hospital admissions and 36 percent of all non-obstetric, non-trauma uninsured admissions were considered medically preventable, had the patient received timely primary care (and complied with medical advice).[1] Sixty-three percent of the medically preventable admissions had a chronic medical condition. A disproportionate share of medically-preventable admissions occur in low-income areas of the District (Table 2). Moreover, about 83 percent of the uninsured admitted to a hospital were admitted on an emergency basis.

[1] DCHA Prospective Uninsured Patient Survey conducted by Lewin-VHI during the spring of 1988.

TABLE 2
MEDICALLY "PREVENTABLE"/"AVOIDABLE" ADMISSIONS
DISTRICT RESIDENTS

	PERCENT OF ADMISSIONS DEFINITELY/PROBABLY MEDICALLY "PREVENTABLE"/"AVOIDABLE"*	MEDIAN INCOME 1980
Congress Heights	63.0%	$12,926
Benning Heights	54.8	13,257
Trinidad/Ivy City	53.9	14,169
Anacostia	48.7	14,142
Adams Morgan	32.4	11,828
Colonial Heights/Petworth	30.0	16,863
All other areas	26.8	$21,436
DISTRICT TOTAL	**41.5%**	**$18,191**

* Non-OB, non-trauma admissions only.
SOURCE: DCHA Prospective Uninsured Patient Survey conducted by Lewin-VHI, 1988.

C. PROVIDER SUPPLY

Our survey of uninsured patients suggests that there are substantial primary care access problems in the District. The data suggests that the problem is not a shortage of physicians. There are an average of 4.9 physicians per 1,000 persons in the District compared with a national average of about 2.0 physicians per 1,000 persons (Figures 8 and 9). Although only 29 percent of physicians in the District are primary care providers, the number of primary care providers per person in the District is about twice the national average. It is important to note, however, that these per-capita physician figures overstate the physician supply in the District because many individuals in suburban Maryland and northern Virginia rely upon District physicians for their care.

Physicians in the District tend to locate in the more affluent parts of the city where privately-insured persons live. Providers are less likely to be found in areas of the city where

there are large numbers of uninsured persons, such as Adams Morgan, Anacostia, Benning Heights, Trinidad/Ivy City, and Congress Heights (Map 1).

Physicians avoid locating in these areas because it is often economically unfeasible to do so. The uninsured are typically unable to pay for their care. While many of the individuals in these areas have Medicaid coverage, Medicaid payment rates are about 60 percent less than private payment rates. In fact, nationwide, Medicaid payments for physicians' care are about 40 percent less than Medicare. Another barrier to locating in these areas is that it is often difficult to entice privately-insured patients from surrounding areas to use physicians located in low-income areas.

Two low-income areas in the District have been declared health professional shortage areas (HPSAs) by the Bureau of Health Care Delivery Assistance. Access problems for Hispanics in Adams Morgan are so great that all Hispanics living in that area are designated to be in HPSAs. A substantial portion of Anacostia is also designated a HPSA (Map 1). Overall, about 15 percent of the District's population lives in a HPSA-designated area (Table 3).

There are about 23 public and private clinics in the District which provide access to underserved populations. The District maintains several public health clinics around the city and there are several private clinics located primarily in the Adams Morgan area (Map 2). There are also four Federally-funded community health centers, two of which are located in Adams Morgan. Most clinics are located towards the center of the city, while there are only five clinics located across the Anacostia River, where much of the District's low-income population is located. Anacostia, portions of which have been designated a HPSA, is an area where additional clinic services appear to be most in need.

Figure 8
Physicians per Thousand
U.S. and the District of Columbia

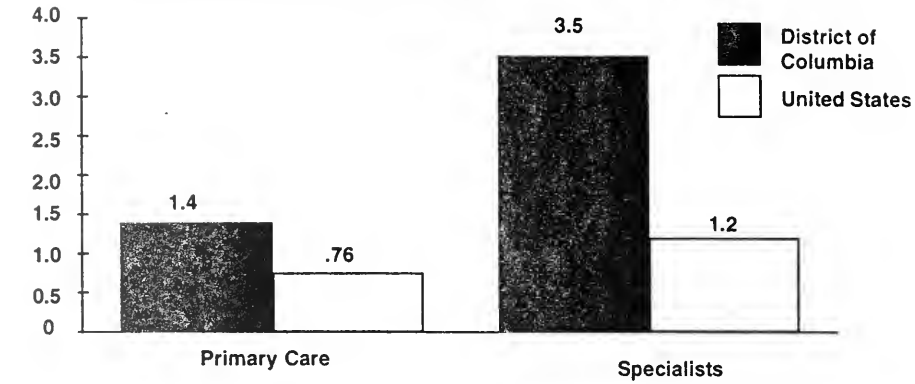
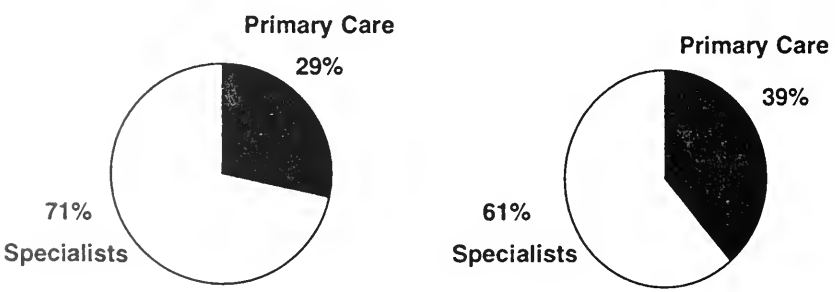


Figure 9
Percent of Primary Care Physicians
U.S. and the District of Columbia

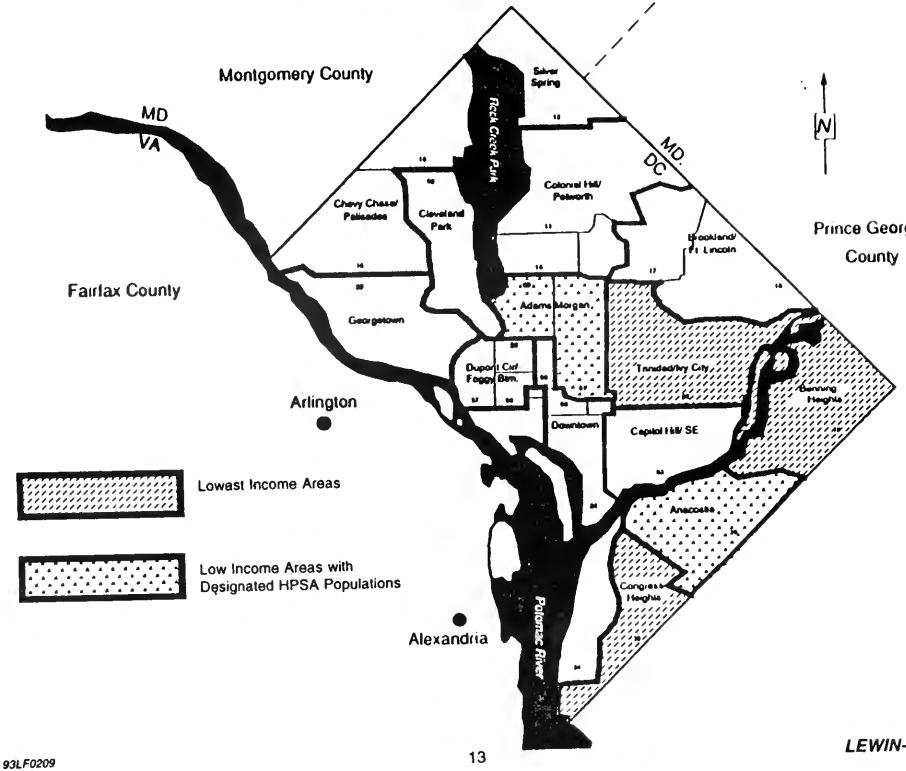


District of Columbia

United States

Source: Physician Characteristics and Distribution in the U.S., AMA, 1992

MAP 1
WASHINGTON D.C. SMALL AREA ANALYSIS



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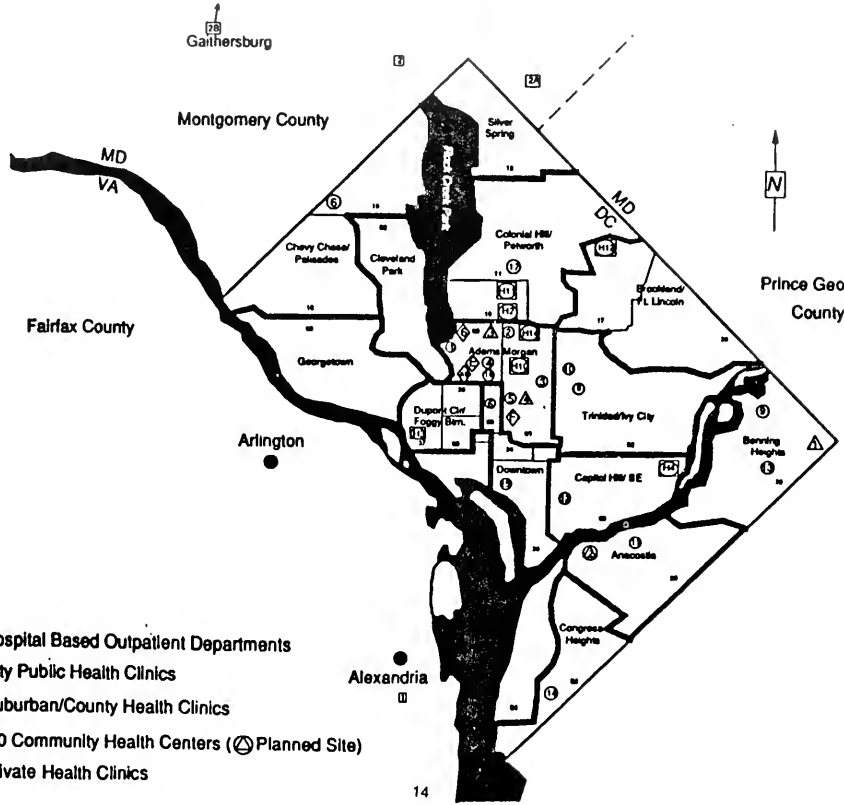
MAP 2
WASHINGTON D.C. PRIMARY CARE CLINIC LOCATIONS



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LEWIN-VHI, INC.

TABLE 3
DISTRICT OF COLUMBIA POPULATION
IN HEALTH PROFESSIONAL SHORTAGE AREAS (HPSAs)

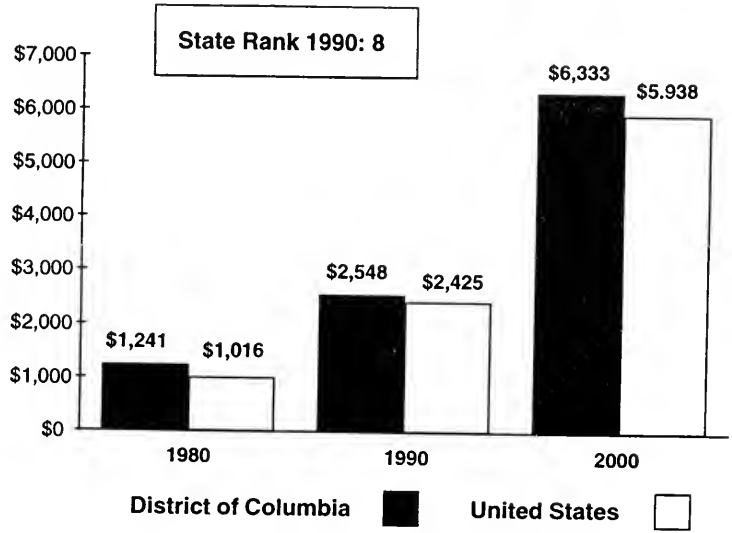
	POPULATION	POPULATION IN HPSAs	% POPULATION IN HPSAs
Anacostia	159,231	74,435	47%
Adams Morgan Spanish Population Group	6,670	6,670	100%
All District of Columbia	529,768	81,105	15%

SOURCE: Health Professional Shortage Area (HPSA) Data File, Bureau of Health Care Delivery Assistance

D. HEALTH SPENDING IN THE DISTRICT OF COLUMBIA

Per-capita health spending in the District is estimated to have been $2,548 in 1990 compared with a national average of $2,425. Per-capita spending in the District is projected to increase to $6,333 by the year 2000 (Figure 10). Per-capita spending in the District ranked as eighth highest among the 50 states and the District of Columbia. Total health spending for District residents is estimated to have been $1.5 billion in 1990.

Figure 10
Per Capita Health Spending in the United States and The District of Columbia

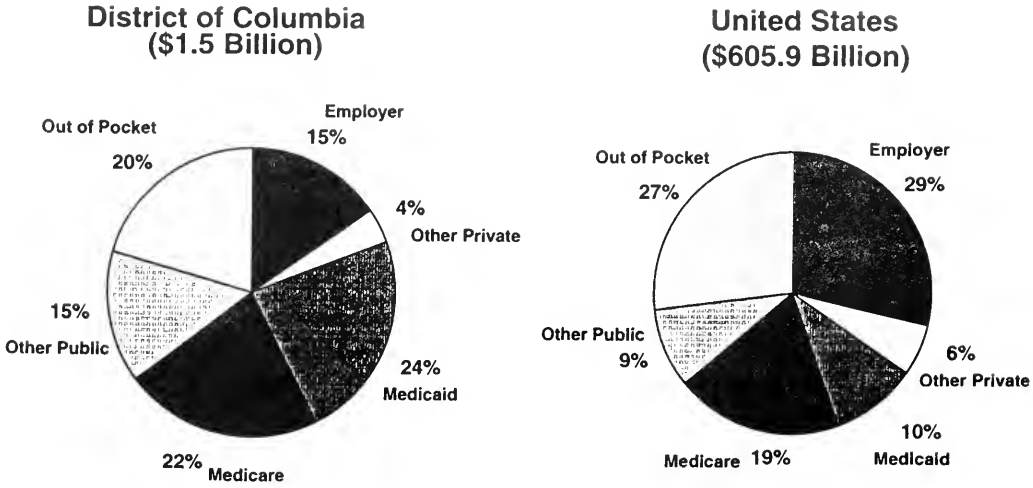


Source: "Rising Health Costs in America: 1980-1990-2000", Lewin-VHI, October 1990.

It is important to understand, however, that hard data on total health spending in the District is not available. While data on spending under public programs for District residents is available from the programs, little information is available on health spending for privately-insured persons and household out-of-pocket payments. Using recent survey data, Lewin-VHI estimated private and out-of-pocket spending amounts for the District of Columbia and each of the 50 states based upon aggregate private spending data by demographic group in the various regions of the United States. The state level spending data used in this analysis was developed by combining these public and private sector data to develop health spending estimates for the District and each of the 50 states.

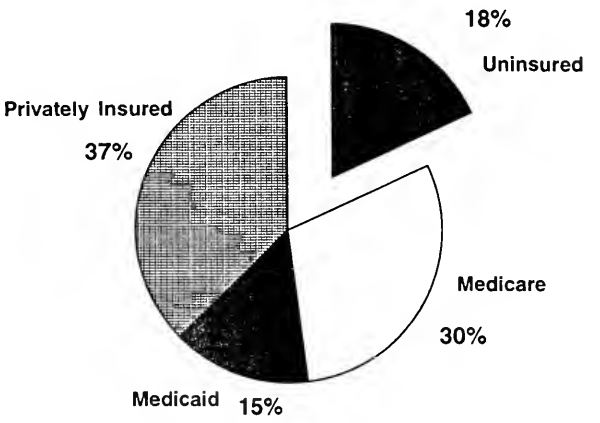
Based upon these data, we estimate that about 39 percent of health care for District residents was paid for by Medicaid or other public programs, excluding Medicare (Figure 11). By comparison, nationwide, Medicaid and other public programs account for 19 percent of health spending. Overall, the uninsured in the District account for about 18 percent of all health spending (Figure 12).

Figure 11
Sources of Payment for Personal Health Care in 1990



Source: "Rising Health Costs in America : 1980-1990-2000", Lewin-VHI, October 1990.

Figure 12
Health Spending for the District of Columbia Residents by Insured Status in 1990 (Total Spending 1.5 Billion)



a) Includes insured amount plus copayment and deductibles.
b) Includes all health spending for insured persons including out-of-pocket payments, uncompensated care, and public programs.

Source: Lewin-VHI estimates using the health benefits simulation model (HBSM).

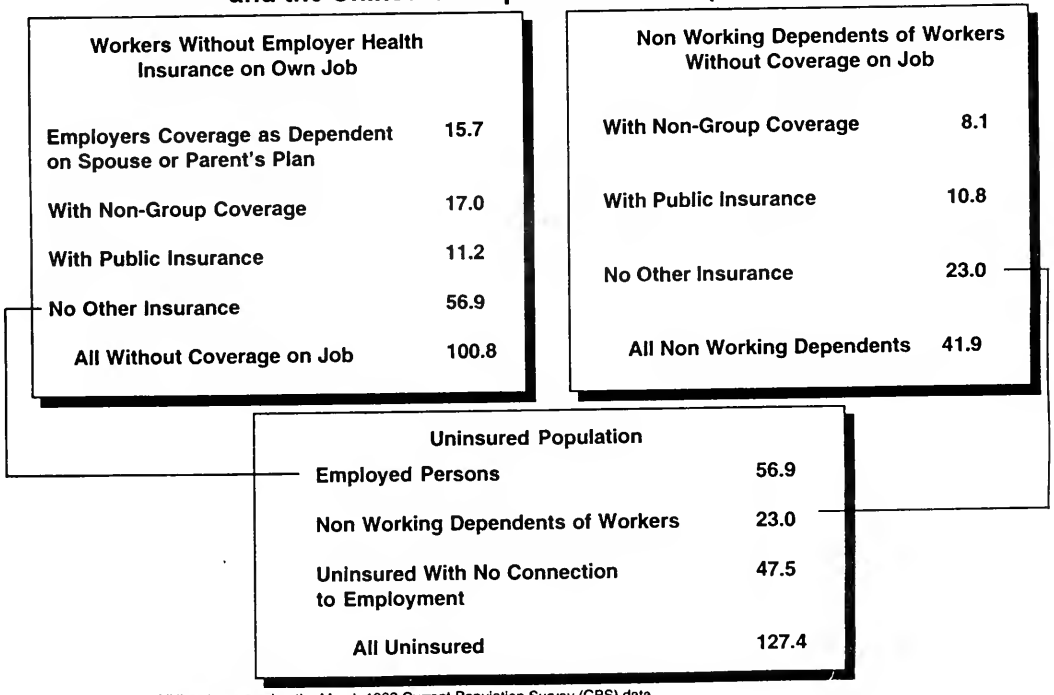
E. EMPLOYER COVERAGE AND THE UNINSURED

About 63 percent of the uninsured in the District are either employed or are dependents of someone who is employed (Figure 13). By comparison, nationwide, about 69 percent of the uninsured are associated with employment either as workers or dependents. This has led many to suggest that much of the problem of the uninsured can be addressed by requiring employers to provide health insurance.

However, a closer examination of the data indicates that such a program would still leave a substantial portion of the problem unaddressed. For example, our 1988 survey of uninsured persons using emergency room services indicated that fewer than 30 percent of the uninsured patients admitted to District hospitals are employed and that only 43 percent are in families linked to the work force. Also, about half of all uninsured workers are out of the labor force for part of the year, indicating that many workers and dependents would continue to be uninsured for at least a portion of the year.

Moreover, workers without coverage on their jobs have very different employment characteristics than workers with insurance. About 52 percent of uninsured District workers are in firms with under 25 workers (Figures 14 and 15) and 70 percent are in the services and trade industries (Figures 16 and 17). About 40 percent of uninsured workers earn less than $6.25 per hour (Figures 18 and 19) and 26 percent are part-time workers (Figures 20 and 21). This employment base may not be able to sustain the cost of health insurance. For example, in an analysis of national data, we estimated that about half of all small firms that do not now offer insurance would find that the cost of insurance would be in excess of 10 percent of payroll (Figures 22 and 23).

Figure 13
Relationship Between Workers Without Coverage on their Job and the Uninsured Population in D.C. (in thousands)



Source: Lewin-VHI estimates using tha March 1992 Currant Population Survey (CPS) data.

Figure 14
Workers in Small Firms in D.C. are Less Likely to be Covered on their Jobs

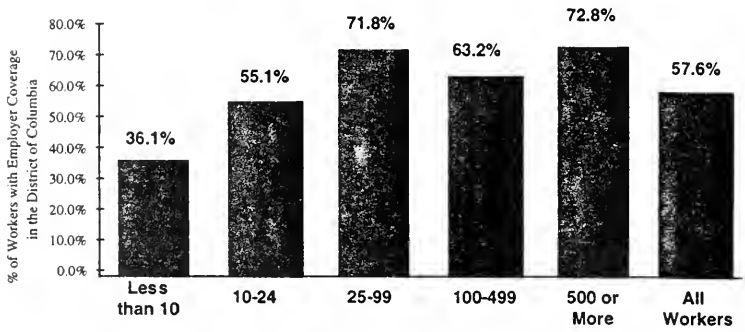
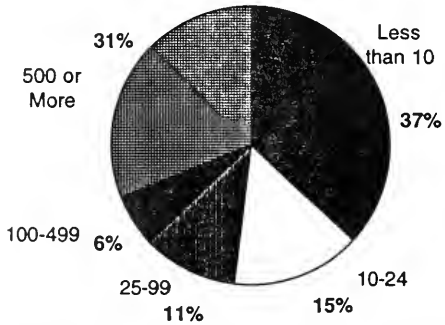


Figure 15
Over 50% of All Workers Without Employer Coverage on their Jobs in D.C. are in Small Firms



Source: Lewin-VHI analysis of the District of Columbia subsample of the 1992 Current Population Survey (CPS) data.

Figure 16
The Percentage of Workers with Coverage on their Jobs in D.C. Varies Widely by Industry

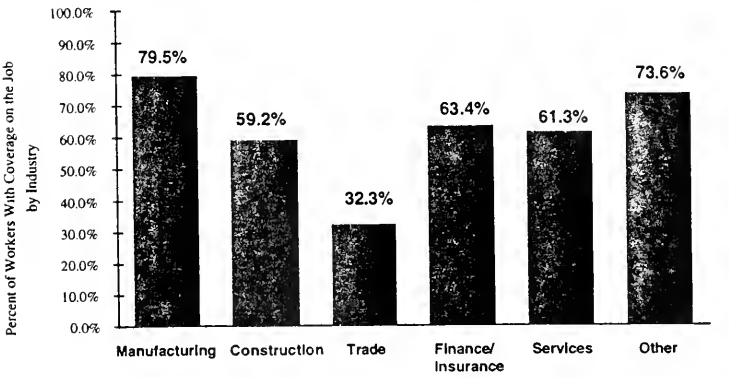
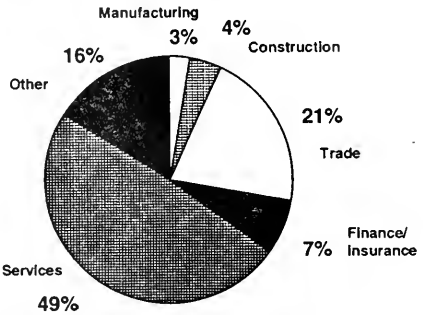


Figure 17
About 70% of Workers Without Coverage on their Jobs are in the Service and Trade Industries

Workers Without Coverage on their Job By Industry



Source: Lewin-VHI analysis of the District of Columbia subsample of the 1992 Current Population Survey (CPS) data.

Figure 18
Employer Coverage in D.C. is Most Prevalent Among Higher Income Workers

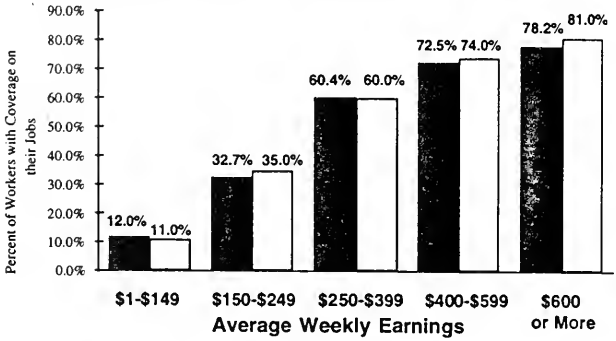
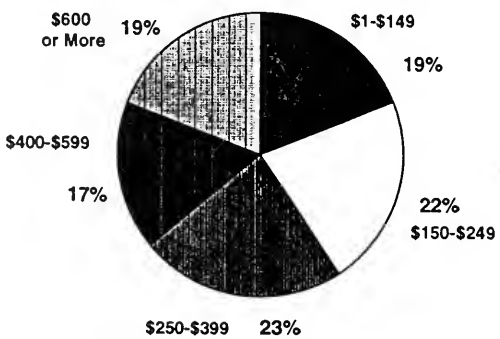


Figure 19
Over 40% of Workers Without Coverage on their Jobs in D.C. Earn Less Than $250 Per Week ($6.25 Per Hour)



Source: Lewin-VHI analysis of the District of Columbia subsample of the 1992 Current Population Survey (CPS) data.

Figure 20
Full-Time Workers in D.C. are More Likely to Have Coverage on their Jobs than Part-Time Workers

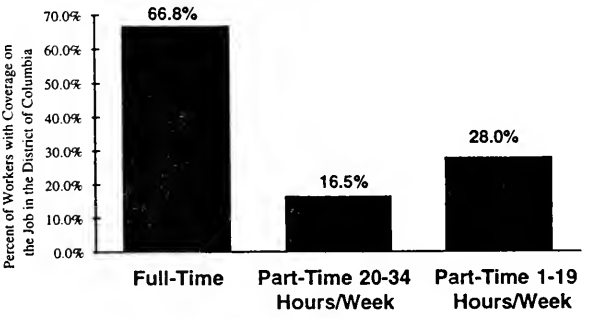
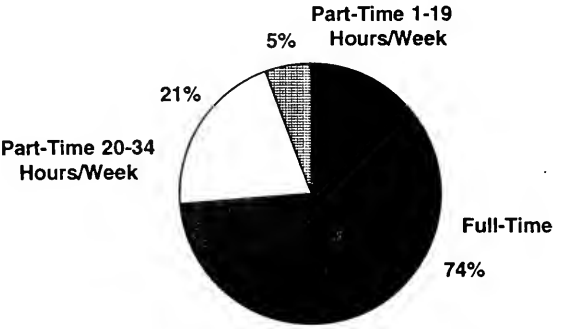


Figure 21
One Out of Four Workers Without Coverage on their Jobs in D.C. are Part-TimeWorkers



Source: Lewin-VHI analysis of the District of Columbia subsample of the 1992 Current Population Survey (CPS) data.

Figure 22
Percentage of Small Firms Offering Insurance by Premium as a Percentage of Payroll, (nationwide data)

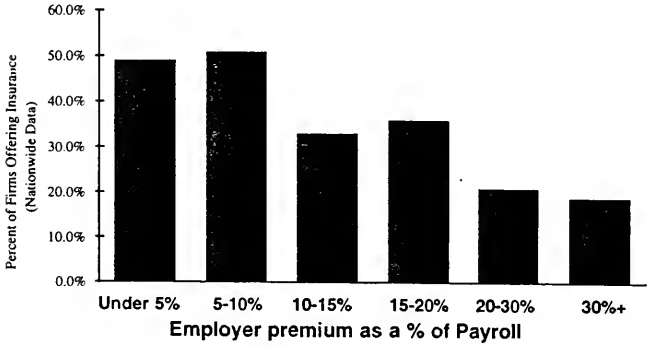
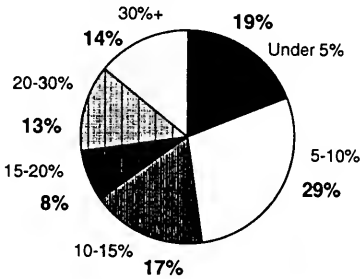


Figure 23
Non-Insuring Firms With Under 25 Employees by Health Costs as a Percentage of Payroll (Nationwide Data)



* Includes firms with under 25 workers. Calculations based on employer share of premiums (80 percent).

The CHAIRMAN. Thank you. Thank you both.

I want to go, first of all, to Mr. Coronado. The numbers that we have tried to patch together to just establish come from both of you and just our own extrapolation and we all come very close. I mean I see in a table that the staff has prepared for me 132,000 uninsured and about 110,000 medicaid.

What I am concerned about, and perhaps Mr. Coronado could indicate this to me—would you want to guess for me or maybe you know, of the 120,000–130,000 uninsured, how many of those do you think qualify for medicaid but have not enrolled? I mean would pass whatever the tests are but for one reason or another never apply or it is difficult for them or we just don't have the resources to screen. You want to hazard a guess.

Mr. CORONADO. Well, it would have to be that because, as you know, when people seek health care usually what happens is that the provider helps them, particularly if it is a hospital, helps them try to become eligible for medicaid. For example, with D.C. General, the report that was put out, the GAO report that was put out not too terribly long ago, one of the things that I noticed is that there was not analysis of the age and sex distribution of those people who got uncompensated care. Someone was kind enough to provide that—Mr. Chastang was kind enough to provide those data to us.

Most of those people were males between the ages of 21 and 64, and that is a category of individuals who are not likely to ever become eligible for medicaid unless they become disabled. So I would suspect, guessing again, because as I say it has to be a guess, that probably there would be a range between, say, 10 and 25 percent of that uninsured population that might be eligible.

The CHAIRMAN. Somewhere between 15,000 and—well, between 10,000 and 20,000—10,000 and 30,000 maybe——

Mr. CORONADO. Possibly.

The CHAIRMAN [continuing]. That the Federal Government should pay for, and the District would save some money if we could identify them.

Mr. CORONADO. Could pay for?

The CHAIRMAN. Yes.

Mr. CORONADO. You know, again, you have to remember that for some people medicaid eligibility is automatic—those who are on AFDC. But for most of the rest it is something that is sought out as a result of accessing the health care system. These individuals who are uninsured up until the time that they need health care usually don't even think about how they are going to get coverage and they actually delay.

Mr. SHIELS. We have actually taken a look at that question empirically and nationwide we have estimated that about 28 percent of the people who are eligible for medicaid never bother to enroll.

The CHAIRMAN. One other number that is rattling around, at least in my mind, is that there are only about—I think the number is 2,500, maybe it is 3,500, long-term-care beds in the District of Columbia, and therefore the figure I see is that only about that many, 2,000 or 3,000, medicaid beneficiaries are in long-term care. Am I missing something there? That seems like an awfully low number to me.

Mr. CORONADO. Actually, in 1992 we had 4,955 individuals——

The CHAIRMAN. Four thousand?

Mr. CORONADO. Nine hundred and fifty-five.

The CHAIRMAN. Let's call it 5,000.

Mr. CORONADO. All right.

The CHAIRMAN. I like to round these things.

Mr. CORONADO. Who have long-term-care services. But the average length of stay for a long-term-care patient, a medicaid long-term-care patient in the city is 183 days. So at any one time we have about 2,900 patients who are in nursing home beds in the city. We have an additional 400 or so who are in nursing home beds in other States.

The CHAIRMAN. What do you suppose the demand is? Is that because you do not have the beds or you do not have people——

Mr. CORONADO. Well, there is a waiting list. If your question is why do we have 408 outside of the city——

The CHAIRMAN. No. I am just saying what if somebody built—could you use another thousand beds for medicaid-eligible seniors? Would they use them if they were there?

Mr. CORONADO. Well, actually what—well, we have just had another nursing home come on-line, Capitol Hill, not too terribly far from here, and there is some discussion on the part of some hospitals who are trying to convert some of their excess capacity into nursing home beds or at the very least swing beds.

But what we would prefer to do to the extent possible is keep people out of nursing homes.

The CHAIRMAN. I understand that.

Mr. CORONADO. One of the things that we are doing is developing a waiver so we can do just that very thing. So that we can provide services in the community.

The CHAIRMAN. Yes. But let me—at least in the places I go around the holidays, up in the Shaw and areas like that, where we take Christmas baskets or food baskets, I am not so sure that living 3 and 4 in an apartment where you use the gas stove to heat it, I do not know whether those qualify as licensed facilities but I, given the choice, would rather be in a nursing home, it seems to me, where I thought that the heating and ventilating worked and food was available.

So I guess my question is when you converted Capitol Hill Hospital or when it converted to a nursing home, will medicaid pay the full freight? I do not know. There is a couple hundred beds over there. Are they taking medicaid eligibles at the medicaid rate?

Mr. CORONADO. Yes, they are.

The CHAIRMAN. Are they full?

Mr. CORONADO. I couldn't really answer that, to tell you the truth. I know that we pay the cost for 96.5 percent of all nursing home residents in the city.

The CHAIRMAN. How big is the waiting list?

Mr. CORONADO. There is a need for about 600 beds in the city. The waiting list is slightly different from that. About 300 people are on the waiting list at any one time.

The CHAIRMAN. Ms. Norton?

Ms. NORTON. Thank you, Mr. Chairman. Could I ask, Mr. Coronado, first, page 1 of your testimony, you indicate that 106,142 resi-

dents were covered by medicaid and that the number would increase in fiscal year 1993 to 112,000. Then in the last sentence you say, "We are expecting to keep program expenditures at last year's level."

Mr. CORONADO. Yes.

Ms. NORTON. Would you explain how you will be able to do that given the increase in the number?

Mr. CORONADO. Of course. One of the things that we are doing is we are developing a program of managed care for the AFDC and AFDC population. They represent about 70,000 of our total population. We are expecting that this will bring costs down considerably.

We are also doing a number of other things that——

Ms. NORTON. When is that going to be put in place? Is that in place now?

Mr. CORONADO. Not yet. We are in the process of actually developing the program. We have gotten a waiver from the Federal Government earlier this month and we expect to have the program up this coming August 1, completely in place and our first clients enrolled in the program.

We are also reforming our payment methodologies for our largest institutional providers. Something that we are, of course, working with them on. That should also save us money.

We are also doing everything that we can to identify those services that are provided with totally District dollars, that could be covered by medicaid such as some of the school health costs, services that are now provided in public health clinics that are not reimbursed by medicaid, that could be and should be reimbursed by medicaid. We are anticipating that we are going to be able to keep costs down like that.

Ms. NORTON. Typically, Mr. Coronado, a D.C. resident who might be classified as working poor, how does that person get health care in the District of Columbia?

Mr. CORONADO. Well, if they are not eligible for medicaid——

Ms. NORTON. I am assuming the person is not eligible for medicaid.

Mr. CORONADO. OK. They would more than likely seek that health care from a public health clinic unless—probably for their child or if it were, of course, a woman who is pregnant she might also seek care there. Otherwise, if it was hospital care that was needed or if it was what they deem to be an emergency, like a sick child late at night, they would appear in a hospital emergency room.

Ms. NORTON. A health care clinic—would that care be provided on a sliding scale? What fee would be charged in a health care clinic?

Mr. CORONADO. Well, if it is a public health clinic, if it is one that is run by the Ambulatory Health Care Administration, there is no fee scale for most of the services that they provide that we think of as primary care. It is totally free. Some of the private clinics do have a sliding fee scale, some of the federally financed clinics.

Ms. NORTON. Now, if someone goes to an emergency room with something that might be taken care of in a public health care

clinic, does the emergency room then refer the person to the health care clinic?

Mr. CORONADO. Well, more often than not they would tend not to, depending on what the facility was. It would certainly look at them because as Chairman Stark mentioned they do have an obligation to at least stabilize a patient, to make certain that they are not representing with some true emergency. They will do that and then they might refer them. Or if it is D.C. General, given their mission and the way that they look at their mission, they may just go ahead and treat that individual.

Ms. NORTON. If the person goes to an emergency room at a private hospital, and the person does not need a stabilization, what is the procedure at that emergency room location for dealing with that person who is poor but does not qualify for medicaid?

Mr. CORONADO. That is a question that I think would best be referred to the hospitals. You know their policies are all pretty much the same. They will see people. They will make certain that there is not an emergency. What they do with them beyond there is——

Ms. NORTON. The city does not have a policy that it recommends for hospitals throughout the city? It is left to the individual hospital?

Mr. CORONADO. I am not aware that there is such a policy. However, I will study that and make certain that there is an answer for that question that is put in the record.

[The information follows:]

[The information was not received in time for printing.]

Ms. NORTON. Finally, what form of relief from rising medicaid expenses has the District applied for or do you believe would be appropriate to be rendered the District?

Mr. CORONADO. Well, frankly, I think that the formula that is used to calculate the Federal share for the medicaid program does a great injustice to the District. It is a formula that is based on per capita income and it assumes a normal distribution of income in the State, and the District, of course, is not like other States in that it does not have a large industrial base, it does not have large farming areas, so its income distribution is not along the normal curve. It is more bimodal. There are large numbers of people who are very wealthy and large numbers of people who are very poor, and that center that normally evens it out is just not here.

Consequently, I think that the formula, because it does not consider the number of people that we have who are below the poverty line, does not give us what it should be giving us. However, that is in law. It is part of the Social Security Act and certainly it is in the Code of Federal Regulations, and changing it is extremely difficult for a wide variety of reasons.

It is something that we have discussed with individuals in the Federal Government, but we have not taken any formal action to see that it is done.

Ms. NORTON. So you think the only action that could be taken then would be for the formula to be changed?

Mr. CORONADO. Yes. I think that would yield us more money, money that we need to see that we get the kinds of funds that we should be getting from the program.

Ms. NORTON. Finally, Mr. Shiels, I was concerned at the figures in your testimony on the growth in uninsured in the District from 97,000 to 127,000 at a time when the District's population has gone down fairly precipitously. Looking for a reason for the growth in uninsured as the number of people is not growing, I would be interested in either your knowledge or your speculation on that subject. For example, has the recession had anything to do with it?

You note the growth in the Hispanic population and that Hispanics tend more often not to be covered. I notice that Adams Morgan in your testimony is one of the sections of the city which is most underserved by physicians.

I don't know if these or if other reasons would account for the growth in uninsured at a time of population decline, but I would be interested in your answer.

Mr. SHIELS. This is a problem that is—these figures are showing up everywhere in the country right now. Last year there were a million and a half more uninsured persons in this country than there were the year before.

Ms. NORTON. Yes. But see there are more people in the country. I am trying to get at——

Mr. SHIELS. Well, even in percentage terms——

Ms. NORTON. All right.

Mr. SHIELS [continuing]. It has been growing quite precipitously. In fact, between 1980 and 1992, I believe, the number of uninsured in this country grew by 10 million persons, and a great deal of it has to do with cost. It is a fairly simple relationship. The more costly health care is, insurance coverage is in general, the fewer people can afford it, whether it be employers or individuals.

Health spending in the United States grew from about 9 percent of GNP in 1980 to over 13 percent by 1992. I believe those figures are accurate. They are roughly accurate. Yet despite this massive infusion of the national wealth into the health care sector the number of uninsured during that period, that same period, grew by 10 million persons.

I think the percentage terms nationwide, the percent of the population without insurance was in the neighborhood of 11 percent in 1980 and it climbed to about 14 percent in the most recent figures. So this is not a problem that is unique in any particular way to this city.

Now, there are certainly unique circumstances which affect it, and the recession hits everybody in this area. The District has a history of being somewhat insulated from recessions historically. That was not the case the last time around.

So I think that the city is suffering from, really, problems which are fairly typical throughout the country. When you lose coverage, particularly loses of coverage driven up by cost, where cost is the primary factor, urban centers where you have lower and middle-income families that is where you are going to see the problem hit the hardest.

Ms. NORTON. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. McDermott?

Mr. MCDERMOTT. Thank you, Mr. Chairman.

One morning I got up and was listening to WAMU and was sort of knocked off my feet by realizing that Anacostia had been desig-

nated as an underserved area. I see in your testimony you talked about that on page 11. Could you tell us how that definition is set up? How does an area fall into that category? It seems appalling that the Nation's Capitol would have an area that we are going to send a Health Service Corps physician to.

Mr. SHIELS. Well, the criteria have to do with the number of physicians, clearly, in the area. There are other factors that go into it.

Mr. MCDERMOTT. What are actually the criteria? Do you know?

Mr. SHIELS. I don't have them with me. There are 9 or 10 different items. The criteria include things like infant mortality, low birth weight, and I believe incidence of reportable diseases. These indicators, together with a shortage of physicians, a clear shortage of physicians in that area, together are used to determine whether an area should be so designated.

I am not an expert in that, and I apologize for not having the materials. I could get you those materials this afternoon.

Mr. MCDERMOTT. I would appreciate it if you would give me those criteria.

[The information follows:]

[The information was not received in time for printing.]

Mr. MCDERMOTT. Can you imagine a situation in a managed competition where anyone would want to go in and provide the health care in an area like that?

Mr. SHIELS. Well, under managed competition—this is a tough answer. I mean it has never been tried before, so I can't give you a definitive answer. Anything I give you is speculative.

Under any system, though, if you achieve some equity in reimbursement rates, you can look forward to broader access. In West Virginia and a number of States there is some experience here in the sense that with the recent developments in the provider tax in the medicaid program a number of States were able to substantially increase reimbursement. In West Virginia, for example, there was a dramatic—and I can get you these figures as well. I don't have them with me. But there was a dramatic increase in the number of physicians who were prepared to take, who were willing to take medicaid patients.

The reimbursement rates, the equity in reimbursement rates which is implied under a managed competition model——

Mr. MCDERMOTT. That you would be paid the same if you were dealing with a so-called medicaid patient or a private patient.

Mr. SHIELS. Right.

Mr. MCDERMOTT. Everybody would be paid the same.

Mr. SHIELS. That is exactly right, and that is one of the strengths of managed competition in that you really can't discriminate. People pick any plan they want in a managed competition environment, and they have to be treated with equity. They have to be treated the same way that everyone else is treated.

This too is one of the strengths of single payer. Everyone has to be treated in exactly the same way. One of the disadvantages of systems which build upon mixes of public and private programs is that the pressure will always be there to cut the reimbursement rates in a public program. The private sector—we are talking about low income, disenfranchised populations who, frankly, may not have the political clout that everyone else has, and in that kind of

environment when you have the public/private payer mix you have greater pressure to reduce the rates in the public programs and, in effect, cost shift.

Now, in a broader sense, though, the question of managed competition is will providers in inner city areas—will providers still want to locate in inner city areas? I don't believe you can expect to see substantial changes in that kind of behavior.

Mr. McDERMOTT. Positive changes?

Mr. SHIELS. No.

Mr. McDERMOTT. You can't imagine doctors moving out from whatever—ward 2 or 3 and going out to Anacostia to practice?

Mr. SHIELS. I don't see that. I don't see that happening in the way that we would like to see it happening. You clearly will get something in a positive direction because under managed competition and under the single payer program both, you have equity in the way that providers are reimbursed for services, at least that is one of the objectives, and you will see things move in a positive direction.

There are some very unfortunate issues that are, frankly, very difficult to talk about here, issues related to how people feel about other ethnic groups and that sort of thing, that are a complicating factor here, that may be a barrier to this kind of shift that you are looking for.

Ms. NORTON. Would the gentleman yield?

Mr. McDERMOTT. Yes.

Ms. NORTON. Would not this be an opportunity, though, for some forms of HMO's, guaranteed payment under a national health care system, to find an incentive to move where private doctors might not?

Mr. SHIELS. Well, I think you are making a—clearly that is an example of where you will get something moving in a positive direction. It is a market. It is a market that could be lucrative, because the payment could be reasonable.

I think the managed competition model, though, you have to be very careful about it. One of the key elements in its design feature, and even the proponents will tell you it is very important to have, to avoid adverse selection; that is, avoid selecting—lining up with a particular type of people in your plan.

Now, targeting a particular area of the city opens up all kinds of opportunities for what we call adverse selection, getting very high risks or going after very good risks, and those things create a destabilizing influence in these managed competition models. The whole question of particular groups targeting particular populations, that opens the door to a continuation of two-tiered systems of care, which is something that I think people want to try and avoid.

Mr. McDERMOTT. You are suggesting, though, that a geographic targeting has an adverse selection element to it. One would assume that if insurance—I mean the number of diabetic patients and the number of high blood pressure patients and so forth are sort of universally spread across the country. So if you targeted geographically, why would you get adverse selection in an area like that?

Mr. SHIELS. It is really the whole idea of trying to target individual populations. It is not so much that targeting geographically is going to give you the result. It is that when insurers engage in ad-

verse selection they are looking for the better risks, period. You have a system here where people are able to pick groups that they can target to, the concern is that you will get insurers seeking out the best groups.

Now, in fairness to the managed competition model, what they want to do is establish a health insurance purchasing corporation, a HIPC, whose job it is to coordinate the sale of coverage, so that in fact the insurer's ability to market in any particular way is greatly restricted. So the purpose of the HIPC is to provide information, information on prices, information on the type of services that are provided, and individuals choose from the information provided by the HIPC.

Now, there is a lot of debate over this particular issue, but the idea here is that if the information, the marketing, if you will, is handled through a neutral party providing objective information that you could avoid many of the problems.

Mr. McDERMOTT. You would imagine then that a—if you want to use that term HIPC, I think they have changed the name now to consumer health alliance, but if you were to market in the District you would have to open it to everybody in the District. You could not say that we would not take people south of this line or west of that line.

Mr. SHIELS. Well, as a practical matter, if your offices are located in northwest DC., you are, in effect, selecting the population that you want to serve. If another organization has their offices located in southeast DC., it is clear that they are going to get a different mix of patients.

Mr. McDERMOTT. Let me ask another question. I want to move on to page 22 in your testimony because I want to understand what is your definition of a small firm. Whenever I hear we have to have subsidized small firms and so forth I—and for the purposes of your graph at the bottom of the page, you say over 50 percent of all workers without employee coverage are in jobs in the District of Columbia are in small firms, and then I see 500 or more.

Now, you have a third of the people are working for companies with 500 or more employees. Are they included in your small firm definition?

Mr. SHIELS. No, they are not. Our definition of small firms—I am sorry that is not clear—is under 25.

Mr. McDERMOTT. Is under 25.

Mr. SHIELS. There is a less than 10 group and the 10 to 24 group.

Mr. McDERMOTT. Is this a reflective figure across the country, that a third of the people are working for firms above 500 employees and don't have health benefits? Is that comparable nationally?

Mr. SHIELS. That it is not uncommon. No, that is reflected in the nationwide data. Yes. A lot of larger firms—go to a large retail establishment. You will find that the manager is probably insured, but the person who served you behind the counter probably is not.

Mr. McDERMOTT. That is because of the part-time nature or the number of hours they work or they simply don't offer it?

Mr. SHIELS. Could be the number of hours. It could be some notion of part-time which has nothing to do with hours. There are a lot of part-time workers—people who are called part-time who work 40 or more hours a week. It could be a temporary position. It

could be they are allowed to have different insurance rules, different coverage rules for different—for various groups of employees with the firm.

Remember there is some debate over the section 89 regulations, nondiscrimination regulations. That would have to a large degree prohibited this, but those provisions were never——

Mr. McDERMOTT. Implemented.

Mr. SHIELS [continuing]. Never advanced.

Mr. McDERMOTT. So any bill or any piece of legislation that comes out of the Congress, including an employer mandate, is, in fact, going to be a mandate on a lot of large firms as well?

Mr. SHIELS. Oh, yes. There is talk that the mandates would come in and actually start with the larger firms.

Mr. McDERMOTT. I think the general myth in the Congress and in the American public is that somehow it is only small businesses that don't cover their employees. But, in fact, the fact is that more than a third or close to a third are large companies?

Mr. SHIELS. Yes, 500 or more. We have the national data. I can send you the raw data too, if you like.

Mr. McDERMOTT. I would like to see it.

[The information follows:]

[The information was not received in time for printing.]

Mr. McDERMOTT. Are these people considered employees working full time when you say a third or——

Mr. SHIELS. I think it is important to understand that the workers who don't have insurance coverage on their job today, they don't look anything like the people who do have coverage on average. They are people who are much lower wage. I have the figures here. The majority, I believe it is—let's see. If I could take just a second here.

[Pause]

Mr. SHIELS. All right. Let me just read from my testimony. About 52 percent of uninsured District workers are in firms with under 25 workers, 70 percent are the services and trade industry where there is a lot of turnover, lots of job turnover. That is a special problem.

Mr. McDERMOTT. So, if you don't last 6 months you don't get the benefit?

Mr. SHIELS. Well, not just that. But you might be working there for 6 months and unemployed the other 6 months. So, even if you give them coverage on their job, you still have to give them coverage for the other 6 months somehow, presumably through some sort of public program.

About 40 percent of the uninsured earn less than $6.25 an hour, and many of these individuals are truly part-time. Let's see; 26 percent are part-time workers, working less than 35 hours a week. That is typical. These figures are typical of the United States, although it is more heavily weighted toward services and trade and small firms in the District of Columbia.

Mr. McDERMOTT. Do you think it would be fair to say that the employment patterns in this country are such that it is going to be increasingly difficult to base a health care insurance program for the United States on employment?

Mr. SHIELS. Increasingly difficult; yes. I think that there is—in fairness to the employer-based approach, there is plenty of room for expansion in that, plenty of room for coverage expansion.

Mr. MCDERMOTT. As long as it is subsidized from the Federal Government?

Mr. SHIELS. Much of it would require subsidy. Not all of it. Not all of it. Some people don't have coverage on their jobs. The firm is making enough money to do it.

Mr. MCDERMOTT. OK.

Mr. SHIELS. I can think of some retail establishments that might be making enough money to cover it.

I think the general point, though, that this population is going to be much harder to insure than the population that already has insurance because of the nature of their employment is very true. People changing jobs all the time. People moving from job to job. People with several jobs. People working in the services. You have a hot band playing in one place one night, you will work there. A couple of weeks later you may find yourself down the street playing somewhere else where the next hot band is. I mean we are talking about a services industry here. Who is responsible for covering the individual for that month? Does coverage change every month?

Those are very difficult practical issues in covering people through employer-based coverage. You mentioned managed competition. It steps away from that half way in that the supplier is supposed to make a payment on the individual's behalf for coverage, but the employer does not actually have to sponsor the plan. So it does move in that direction though it doesn't decouple.

Mr. MCDERMOTT. It becomes more of a, sort of a payroll tax that is paid into a——

Mr. SHIELS. That is right.

Mr. MCDERMOTT [continuing]. Into a purchasing cooperative. Thank you.

I want to ask a couple of questions of you, Mr. Coronado. One of the questions that I keep wondering is whether or not anybody has been able to disaggregate the figures related to the cost of violence in cities. It is a fairly common occurrence in most major cities in the United States that violence is a big part of the cost in emergency rooms and hospitals of America's cities, and I wondered if you have done any kind of analysis of your costs in this city to be able to help us with that kind of a figure.

Mr. CORONADO. The Hospital Association did a study last year, I think it was, perhaps the year before.

Mr. MCDERMOTT. So they will be on later as witnesses today. I will ask them at that point.

The reason I ask is our Senator has proposed a tax of 25-percent increase on the sale of handguns as a way of getting enough money to deal with the cost of violence in the health care system. I don't know whether that is based on actual data or not. So, I would be interested. I hope, if the hospital industry is here, they will think about that because I would really like to know that.

The second question I have is, we spend an enormous amount of money in this country with low birth weight babies, and it is always a puzzle to me why we are willing to spend $100,000,

$150,000 or $200,000 per case after delivery but we can't seem to get it put together before. I understand that at least in some places in the world there are cash payments offered to people to show up for prenatal clinics. I wonder has that idea ever been tried in the District? Has it been thought about? Been discussed?

Our infant mortality rate in this city is such that I think it requires us to look at what the rest of the world has done in this regard.

Mr. CORONADO. Actually, the District has thought about, and the District has done a number of things, you know. The "moms'" van that actually went out on the streets looking for young pregnant women. You know, not just trying to scoop them up. I mean obviously it knew where it was going. The healthy babies program that gets out among the population, identifies women as early as they can. We have had some discussions about incentives, whether positive or negative, that might be used.

There has not really been enough experience in other States yet. Those programs have not been out there that long to really give us a sense of how they are going to work. We are certainly going to look at them, though, and we are going to continue doing other things that we can to help people get identified as quickly as they can and into prenatal care, because obviously people have a choice as to whether or not they need care. You know, certainly a good deal of that choice depends on the education they get about the benefits to themselves and their child, their child-to-be of that care.

One of the things that we have done in the medicaid program is to increase the payment that we give to physicians for the delivery and a minimum of seven prenatal visits, up to $1,750, which is greater than two private plans, because we want to enlist their assistance in getting medicaid clients into prenatal care as early and, of course, as often as we can.

Also, under managed care one of the things that we are going to require is frequent reports on prenatal care. We will expect the managed care providers tc identify women early in their pregnancy and see that they do receive care that they need.

Mr. MCDERMOTT. Thank you very much.

The CHAIRMAN. Thank you. Mr. Coronado, let's talk about that managed care a little bit. I am intrigued.

You now have about 15,000–16,000 AFDC beneficiaries covered under it?

Mr. CORONADO. Yes.

The CHAIRMAN. How much do you pay a year for those?

Mr. CORONADO. We paid about $20,000 last year.

The CHAIRMAN. I beg your pardon?

Mr. CORONADO. Twenty thousand.

The CHAIRMAN. How much a head? What is the capitated rate?

Mr. CORONADO. It is $95 for a child, and it is $178 for an adult.

The CHAIRMAN. Ninety-five, that is $1,140 a year?

Mr. CORONADO. Yes.

The CHAIRMAN. For a child. How much, $2,136 for an adult.

Mr. CORONADO. One hundred and seventy-eight.

The CHAIRMAN. I beg your pardon?

Mr. CORONADO. One hundred and seventy-eight dollars for an adult.

The CHAIRMAN. Twenty-one seventy-eight?

Mr. CORONADO. No. One seventy-eight. One hundred and seventy-eight.

The CHAIRMAN. Two thousand one hundred and thirty-six dollars a year?

Mr. CORONADO. Yes.

The CHAIRMAN. For an adult. Those are all under—I would assume the average age is quite low. Under 65, certainly.

Mr. CORONADO. Yes.

The CHAIRMAN. Under 30?

Mr. CORONADO. In that range; yes, sir.

The CHAIRMAN. OK. Now, and that is all through one provider; correct?

Mr. CORONADO. That is correct.

The CHAIRMAN. You are going to add, it is my understanding, 70,000 medicaid beneficiaries to this program; is that correct?

Mr. CORONADO. It will be a total of 70,000.

The CHAIRMAN. I am sorry. So you are going to add about 55,000.

Mr. CORONADO. That is correct.

The CHAIRMAN. You plan to do that this year or next year?

Mr. CORONADO. This year.

The CHAIRMAN. How much are you going to pay, do you think, when you have—you got an idea of what you will be paying when you have the total of 70,000?

Mr. CORONADO. We are still working out the rate.

The CHAIRMAN. Well, give me a range? What is their last best offer?

Mr. CORONADO. Well, it is not a question of last best offer. What we are doing is looking at the cost figures for the population.

The CHAIRMAN. How do you determine the cost figures?

Mr. CORONADO. Well, we know what we pay for them, what kind of utilization we can expect to see given——

The CHAIRMAN. Wait a minute. You have already been paying $2,136 for adults and $1,140 for children.

Mr. CORONADO. No. What I am talking about is the cost of providing services to the 70,000 population.

The CHAIRMAN. Let's start with the 16,000. Do you think it is going to be more——

Mr. CORONADO. I expect it is going to be less.

The CHAIRMAN. Less. How much less?

Mr. CORONADO. That is very difficult to say now because we are still looking at our 1992 figures, at the utilization and at the cost figures.

The CHAIRMAN. You mean you are going to reimburse this provider on a cost basis?

Mr. CORONADO. Not at all. It is going to be a percent—well, Federal regulations say that we cannot pay more than we would have paid under a fee-for-service. Usually what States do is they set a percentage less than fee-for-service.

The CHAIRMAN. Ninety-five percent, let's say.

Mr. CORONADO. Well, we are going to be at 92.5 percent.

The CHAIRMAN. Oh, good. You are not sure how much less than the $2,136 that is going to be?

Mr. CORONADO. Well, actually there is a family cost of about $116, composite for a family. But I can't tell you right now. You see, in fact, I was just talking to Mr. Shiels before we came up here about an actuary, identifying an actuary that could work with us so that we could finalize our rate.

The CHAIRMAN. Wait a minute. You are contracting with a plan; is that correct?

Mr. CORONADO. Yes. But this plan is different, Mr. Chairman. This is a State-regulated plan.

The CHAIRMAN. You mean this is a District of Columbia-regulated plan?

Mr. CORONADO. That is correct. Yes. It is not a federally qualified HMO.

The CHAIRMAN. Yes, I understand that.

Mr. CORONADO. We cannot lock clients into that, into the HMO, and there is flux. The manner in which rates are set under this program are very different——

The CHAIRMAN. Let me ask you this. Do you have a written outline of the requirements of this plan and the details, the rules of how people will be provided care and how much you will pay?

Mr. CORONADO. Yes, we do.

The CHAIRMAN. Do you have a copy of that with you?

Mr. CORONADO. No, I am sorry, I don't, but I can provide you with that.

The CHAIRMAN. Would you provide that for the record?

Mr. CORONADO. Be happy to.

[The information follows:]

DOCTORS COUNCIL
1101 VERMONT AVENUE, N.W., SUITE 405, WASHINGTON, D.C. 20005 (202) 408-3373 FAX: (202) 408-3393

July 15, 1992

David Coronado
Commissioner
Health Care Financing Commission
2100 Martin Luther King Jr., Ave, SE
Washington, DC 20032

Dear Mr. Coronado,

The Doctors Council, representing 326 physicians, dentists and podiatrists employed by DC Government, was greatly interested in HCFC's testimony on June 11, 1992 before the Human Services Committee on bill 9-425. HCFC's references to the positive experiences with the current capitated plan were of particular interest.

Doctors Council bargaining unit members provide direct patient care in all clinics managed by CPH, as well as in Corrections. The ambulatory care clinicians report that they are currently seeing a significant number of Charter Health enrollees, who, for a number of reasons, prefer to seek medical and dental care from neighborhood health clinics. Some physicians and dentists report that up to 25% of their patient load is comprised of Charter Health enrollees. By CPH policy, no patients are turned away; nor do the clinic doctors wish to deny care for any patient. The Doctors Council is concerned, however, that a private health care entity is receiving capitation fees for patients who apparently prefer to be treated at a CPH clinic; while the clinics are denied the authority to bill for medicaid for Charter Health patients, undermining their own scarce funding.

There appear to be several reasons for the return to the clinics of a significant number of Charter Health patients. Among most frequently stated reasons are accessibility of the NHC; preference for clinic provider; an inability to timely schedule with a Charter Health provider; and an inability to formally disenroll due to confusion regarding the disenrollment process. I must also state that the clinic doctors have heard numerous patient stories of hyper aggressive marketing and subsequent failure (or perceived failure) of Charter Health to deliver on promises made to enrollees.

The Doctors Council stands for accessible quality care for DC citizens. We cannot afford to lose scarce health care dollars in this fiscally depleted environment, nor do we believe patient care is enhanced by removing from the patient the right to access neighborhood health clinics. We urge your office to develop a system for re-capturing capitation fees for patients who have elected to return to CPH clinics for care.

The Doctors Council requests that you review this issue, including the surveying of the clinics, and take all actions in your power to assure the right of the patient to select his or her provider, as well as to protect the District's health care revenues.

I appreciate your timely attention to this concern. Please advise me of the results of your review of our concerns.

Sincerely,

Adrian G. Wilson, DDS
President

AGW/saw

C: Vincent Gray

D.C. - 41
APR 1973

Memorandum ⊙ Government of the District of Columbia

TO: Marlene M. Kelley, M.D.
Administrator, AHCA

Department, Human Services
Agency, Office:

FROM: Mohammad N. Akhter, M.D., M.P.H.
Commissioner of Public Health

Date: 3/26/93

SUBJECT: Neighborhood Health Centers and Other Clinic Services to Medicaid Recipients

It has been brought to my attention that in Fiscal Year 1992, Ambulatory Health Care Administration provided in excess of 3,000 visits at AHCA facilities to medicaid recipients who are enrollees of the Chartered Health Plan, HMO.

Inasmuch as such individuals have access to comprehensive health care through a program for which the District government is paying on a prepaid basis, you are requested to refer such patients back to the HMO in which they are enrolled for medical care services.

Before such referrals are made, clinic personnel must assure themselves through a telephone call to the medicaid verification system that the individual is still a member of the HMO in good standing and entitled to receive such services.

The exception to this policy is that dental services to individuals 22 years of age and over will be provided as it is not a medicaid covered service and therefore not provided by the Chartered HMO.

DHS/CPH/AHCA/PCOPPOLA/dav/03/22/93/673-6678
cc: CPH File, Chron
AHCA File

The CHAIRMAN. All right, let's talk about this. Now it is my understanding that in 1992 this plan with 16,000 people in it, that there were over 3,000 visits by those 16,000 people to Public Health Service clinics outside the plan. Is that about right?

Mr. CORONADO. Actually, the figures we had were 1,044.

The CHAIRMAN. I have over 3,000.

You have indicated, and I think Mr. Shiels indicated, and I would ask Mr. Shiels this very quickly, wouldn't you estimate that if we are going to have the 70,000 people, all of whom are medicaid or AFDC, that it is safe to assume that 80 or 90 percent of them are going to come from ward 7 and ward 8? Fair assumption?

Mr. SHIELS. Yes.

The CHAIRMAN. All right.

Mr. SHIELS. Certainly.

The CHAIRMAN. So in ward 7 and ward 8, it is my understanding that this plan has a grand total of seven doctors. Is that about right?

Mr. CORONADO. That is about right. Yes.

The CHAIRMAN. They have a total of under 60, so the other 50 are spread out at some distance from ward 7 and ward 8; is that about right?

Mr. CORONADO. Yes.

The CHAIRMAN. How many doctors do you suppose are going to add—for when you add 55,000 people to this plan?

Mr. CORONADO. They are not going to be the only plan, Mr. Chairman.

The CHAIRMAN. Oh, they are not?

Mr. CORONADO. No, they are not.

The CHAIRMAN. Oh. There is going to be more than one plan.

Mr. CORONADO. Yes, indeed, there will be.

The CHAIRMAN. How many?

Mr. CORONADO. Well, at the moment we have 5 other plans that have expressed very strong interest in participating.

The CHAIRMAN. Good. Can you name those for us?

Mr. CORONADO. Yes. I am not sure—well, certainly I can—you know, it is a matter of public record, the plans that have come and spoken with us. Blue Cross.

The CHAIRMAN. Um-hum. Which Blue Cross? The District of Columbia?

Mr. CORONADO. District of Columbia. They have a partner.

The CHAIRMAN. Whose—Blue Cross District of Columbia, all right. You think they will be in business next year? Well, let's go ahead. Who else?

Mr. CORONADO. OK. Kaiser Permanente.

The CHAIRMAN. Kaiser, all right.

Mr. CORONADO. GHA.

The CHAIRMAN. Who is that?

Mr. CORONADO. Group Health.

The CHAIRMAN. Group Health Association.

Mr. CORONADO. George Washington University Health Plan.

The CHAIRMAN. OK.

Mr. CORONADO. Cigna.

The CHAIRMAN. I have heard of them.

Mr. CORONADO. Health Care Cooperative. It is a group that has formed recently here in the city.

The CHAIRMAN. It is recently formed?

Mr. CORONADO. Yes.

The CHAIRMAN. Does the District have laws or regulations on how a group can form?

Mr. CORONADO. The District's medicaid Program has regulations; yes. We are the ones who regulate them.

The CHAIRMAN. Dr. McDermott and I are planning to form a group like this. What would we have to do to qualify to be a group?

Mr. CORONADO. Well, there are a number of things. You have to incorporate in the District.

The CHAIRMAN. Yes. Fifty bucks, right?

Mr. CORONADO. No. Well, it may cost you $50 to incorporate, but you would have to post a cash bond of $100,000 if you were not operating and had tangible assets that——

The CHAIRMAN. A hundred thousand dollar bond. Would a letter of credit be all right?

Mr. CORONADO. Yes.

The CHAIRMAN. From this bank that deals with—BCCI; yes.

[Laughter]

The CHAIRMAN. All right. So we have our $50 incorporation papers and a letter of credit from BCCI. What is next?

Mr. CORONADO. You have to have providers that are licensed by the District.

The CHAIRMAN. I have Doc here.

Mr. CORONADO. Is he licensed in the District?

The CHAIRMAN. He has reciprocity.

Mr. CORONADO. OK.

The CHAIRMAN. He is in.

Mr. CORONADO. There are a number of other criteria that either relate to the way that you provide service——

The CHAIRMAN. Well, give me the tough ones. So far this has been easy.

Mr. CORONADO. OK. One of the things that you have to do is under the current regulations you must agree that you are going to provide 24-hour coverage. You must agree that you are going to accept patients—must agree that you are going to not turn away patients. You know, that you are going to see the patients that are sent to you that qualify for your plan. Must agree that you are going to provide education with regard to how to access health care. That you are going to provide health education. That you are going to have an agreement system that is in addition to the one that is required by the Federal Government.

The CHAIRMAN. How about the number of doctors I must have per patient?

Mr. CORONADO. That is not currently a part of the regulations. However, it is part of the requirements that we are putting together for our medicaid plan.

The CHAIRMAN. You are going to have a requirement of the number of doctors per enrollee?

Mr. CORONADO. Maximum number of two thousand. Two thousand enrollees per primary care physician.

The CHAIRMAN. What is that, about double the national average? Four times the national average? That sounds high quality.

Now, let's get to the tough—I don't have to have a hospital; right?

Mr. CORONADO. No. But you have to be able to make arrangements to have someone referred to specialty care if you don't provide it or to be hospitalized.

The CHAIRMAN. But I cannot own one of these specialty care things that I refer people to, can I?

Mr. CORONADO. Yes, you can.

The CHAIRMAN. OK. Do I get paid extra for that?

Mr. CORONADO. Extra?

The CHAIRMAN. Well, I get paid my costs?

Mr. CORONADO. No. If you are on a capitated basis, then——

The CHAIRMAN. Aren't they all going to be on a capitated basis?

Mr. CORONADO. If they are HMO's; yes, they will.

The CHAIRMAN. What if they are not?

Mr. CORONADO. Well, the only other—what our current waiver that we have with the Federal Government says is it allows for those physicians who are in the community to continue to practice on a fee-for-service basis?

The CHAIRMAN. How are you going to set those fees?

Mr. CORONADO. We have a fee schedule currently that I would be happy to provide for the record.

The CHAIRMAN. Let's get to the tough part now. I have heard nothing so far that has ended the Stark-McDermott Care For All Corporation. What happens if we fib to you? Or if we turn somebody away? Let's get to the penalty side. Usually at the end of a law you have a little something down there that says in the unlikely event that this does not work out, is there a jail sentence?

Mr. CORONADO. No.

The CHAIRMAN. No?

Mr. CORONADO. The maximum, of course, is forfeiture of the bond.

The CHAIRMAN. But that is BCCI's problem; right? If I sign up 20,000 or 30,000 people and I don't make it, I forfeit the bond, is that what you are telling me?

Mr. CORONADO. Yes.

The CHAIRMAN. What would you pay me for a bond from the Blue Cross Insurance Company in the District of Columbia? If I had a note from them, would you say that was worth face value today?

Mr. CORONADO. I am not sure because I am not sure what their assets are.

The CHAIRMAN. I do not think they are very sure either. OK. Now, I was looking for Mr. Shiels' number of doctors here. How many doctors, Mr. Shiels—you can probably tell me right off the top of your head—are there in wards 7 and 8, primary care? You had an absolute number.

Mr. SHIELS. I do not have those figures with me.

The CHAIRMAN. Wasn't many.

Mr. SHIELS. I do not have those figures in the testimony. I do not have them distributed. We do not have the distribution in here.

The CHAIRMAN. We had them someplace.

Mr. CORONADO. We know——

The CHAIRMAN. Oh, yes. Mr. Coronado, you have it.

Mr. CORONADO. Yes.

The CHAIRMAN. You know. How many docs, primary care docs in wards 7 and 8? Here we go.

Mr. CORONADO. A hundred and eighteen; 118.

The CHAIRMAN. All right. No. No. That is total. You have them all. That is all right. You have 118 out of 1,400. You think 118 docs is enough for 70,000 people?

Mr. CORONADO. Well, they are not all—not all the 70,000 live in wards 7 and 8. There are 32,000 AFDC recipients that live in wards 7 and 8.

The CHAIRMAN. Now, if any of these people sign up—Blue, Kaiser, George Washington, Cigna—will they have to agree to take any resident of the District who qualifies?

Mr. CORONADO. Yes.

The CHAIRMAN. Will they be allowed to sell, to solicit membership?

Mr. CORONADO. You mean market their plans?

The CHAIRMAN. Yes.

Mr. CORONADO. Yes, they will. But there will be restrictions.

The CHAIRMAN. What kind of restrictions are there going to be on the marketing now? Because that is my part of this. He is going to take care of the people in our company. What restrictions are you going to put on me when I sign people up for the plan?

Mr. CORONADO. Well, first of all, there are several. The staff that you use to do the marketing cannot be paid bonuses for the number of people that they enroll in the plan.

The CHAIRMAN. Straight salary.

Mr. CORONADO. Straight salary. You must provide materials on how you provide care, what your hours are, what an individual's rights and responsibilities are if they enroll with your plan. They must be given numbers, emergency numbers if they need urgent care during other than regular office hours. If they are a person who does not speak English, in the case of the District, who speak Spanish, you must provide materials for them that are in both English and Spanish; you know, depending on which one they can read.

You cannot market someone who is a member—you know, who is an enrolled member of someone else's plan already.

The CHAIRMAN. Where does the competition come in here, if I cannot steal them from Kaiser, for Heaven's sakes or Blue Cross?

Mr. CORONADO. There is only one occasion when that can be done, and that is when someone certifies or recertifies.

The CHAIRMAN. You are not going to have open enrollment each year?

Mr. CORONADO. Well, it is going to be each time that they certify or recertify. What we are interested in is continuity of care. Under the current program, since that is not a federally qualified HMO, patients cannot be locked in for any period of time, so they can change from week to week.

The CHAIRMAN. Let's just suppose—I cannot believe there would be anybody in this country that, but it takes one to think of one, that could be so underhanded and scurrilous as to come in and or-

ganize a plan, you know. But say that I was going to organize it. I will not tell you where Dr. McDermott lives but he lives sufficiently far enough away from wards 7 and 8 that if we went in and marketed a plan and signed up 10,000 or 15,000 people, I am sure the doc could take care of them all by himself. But let's suppose after a year or so out of these 10,000 people it turned out that most of them never showed up at our office, kept going down to the emergency room. I would still collect my $2,100 a head, right?

Mr. CORONADO. One of the things that we are going to be requiring is a variety of reports. Our evaluation system is going to be as concerned about underutilization as it is overutilization. We are acutely aware of the fact that——

The CHAIRMAN. How are you going to know whether those people—I have 10,000 people. I am cranking in about 2 million a month, 21 million a year. I figure with that we can go out and hire somebody to write those reports all right. How are you going to know whether the people signed up in my plan are sick or not?

Mr. CORONADO. Whether they are ill, you mean? Is that what you are saying?

The CHAIRMAN. Whether they are ill; yes.

Mr. CORONADO. Well, you know, as I was saying, we are going to require a number of regular reports that are going to give us information by patient name of services that are received.

The CHAIRMAN. Will each patient in my plan have to have a physical?

Mr. CORONADO. Yes; they will.

The CHAIRMAN. Each year?

Mr. CORONADO. Within 60 days of the time that they enroll with you, if they have not already had one in a year. Children are going to have to have an annual EPSDT screen and any other sort of interim screens that are required. They are going to have to have immunization. That is going to be required. We are going to require a report by name that includes the name of the immunization and, of course, the dosage as well.

The CHAIRMAN. You are making this business sound tougher all along.

Mr. CORONADO. Well, it is a lot tougher.

The CHAIRMAN. Keep going. That is what I want to hear.

Mr. CORONADO. For pregnant women, again we are extremely concerned about prenatal care. We want to see woman get prenatal care. We are going to require, again, reports by name, and we are going to verify these reports on a random basis with the individual patients.

There are going to be surveys of patients for client satisfaction. There is going to be a help line that is specifically for clients, for any questions or any complaints that they might have about their plan or questions that they might have about their provider. For example, if the 24-hour number does not work and they feel like they are in urgent need of care, they can call this special number that we are going to have manned 24 hours a day and provide this information.

For example, if the 24-hour number does not work and they feel like they are in urgent need of care, they can call this special

number that we are going to have manned 24 hours a day and provide this information.

Each medicaid client is going to receive information not only about the plan's grievance procedure, but also about the one that is required by the Federal Government in the medicaid program. There is going to be a lot of checks and balances. It is not a normal—it is not like an HMO. It is not like a usual Kaiser-kind of operation.

The CHAIRMAN. Everybody is going to be capitated in this plan.

Mr. CORONADO. If it is an HMO.

The CHAIRMAN. What if it is not an HMO?

Mr. CORONADO. Well, there is a law currently on the books in the District of Columbia that requires that all medicaid providers under managed care be capitated.

The CHAIRMAN. So everybody is going to be capitated?

Mr. CORONADO. Yes.

The CHAIRMAN. So, you are going to tell me that nobody will get more than $2,136 a year? That is what you are paying now, so it is going to be less than that; right?

Mr. CORONADO. Should be; yes. Will be.

The CHAIRMAN. Will be. That sounds pretty good.

Look; I would really like to see if you could provide us for the record the outline or the rules on this. I think you have probably just put Doc and me out of business. But I would like to see what the more financially secure plans would have to qualify for because I think that is something that we are going to get to in the next witness panels.

I want to mention, as I thank these witnesses for their help, that in the District, the District's medical and nursing schools and the Pew Foundation have responded to the committee's staff over the past several months in setting up various public clinics as part of the training for nurses and medical students in the District of Columbia. I do not know there is any other time that I had a chance just for the public record to thank those schools and the foundation for working with us. We hope that will contribute a small part to helping. Mr. Coronado and his office have been most cooperative in that, and we want to thank them very much.

If none of the members have further questions, we want to thank both of you very much for your contribution this morning. It was very interesting.

The CHAIRMAN. Our next panel is comprised of these same folks absent the Stark-McDermott HMO, which just went out of business. We are going to have Alissa Fox, the executive director of congressional relations for Blue Cross and Blue Shield Association, and that, I believe, is the national association; Dr. John E. Ott, who is the chief executive officer of George Washington University Health Plan; Mr. Robert Bowles, Jr., who is president and CEO of the Chartered Health Plan, Inc.

Welcome to the committee. I would like to just ask you to start off in the order that we called your names and proceed to expand on your prepared testimony or enlighten us in any manner you are comfortable.

Ms. Fox?

STATEMENTS OF ALISSA FOX, EXECUTIVE DIRECTOR, CONGRESSIONAL RELATIONS, BLUE CROSS AND BLUE SHIELD ASSOCIATION; DR. JOHN E. OTT, CEO, GEORGE WASHINGTON UNIVERSITY HEALTH PLAN; AND ROBERT L. BOWLES, JR., PRESIDENT AND CHIEF EXECUTIVE OFFICER, CHARTERED HEALTH PLAN, INC.

STATEMENT OF ALISSA FOX

Ms. Fox. Thank you, Mr. Chairman, and members of the committee. I am Alissa Fox, here on behalf of the National Blue Cross and Blue Shield Association.

Blue Cross/Blue Shield provides coverage to D.C. metropolitan area residents in several ways; 420,000 Federal employees and their families are enrolled in the Blue Cross and Blue Shield Federal Employees Program; 18,000 congressional employees are enrolled in BACE, the D.C. Blue Cross/Blue Shield Plan's expanded preferred provider program.

In addition, the D.C. Plan provides a range of health coverage to individuals, small and large groups, and seniors. The D.C. Plan offers PPO, HMO and point-of-service options. These products offer a wide choice of hospital and physicians located in all areas of the city.

Turning to the three health care option reforms under discussion, we believe that the goals of cost control and universal coverage can best be achieved through managed competition. By managed competition, we mean essentially three elements:

First, employers should be required to contribute to a basic benefit package for their employees that includes preventive care. Subsidies should be provided to small employers and low-income individuals.

Second, strict insurance standards should be set and applied to all insurers and self-funded entities. These standards should include community rating, open enrollment, guaranteed renewability, standardized benefit packages, and requirements for streamlined administration.

Third, incentives should be provided to encourage and hasten the movement of consumers into cost effective delivery systems. We caution Federal policymakers not to make reforms entirely dependent on the establishment of a HIPC everywhere. We believe we should first gain experience through HIPC's through targeted efforts at individuals and small employers.

There are a lot of unanswered questions about HIPC's. Who should run them? What are their responsibilities? Who should be covered by them? And what areas should they cover? For example, in District of Columbia, would the D.C. HIPC also include the surrounding metro areas? Would Federal and State employees be included in the D.C. HIPC? For these reasons, we believe HIPC's must be carefully reviewed and tested before implemented nationwide.

I would like to give you an example of the kind of initiative that would be developed under a managed competition approach. The D.C. Blue Cross/Blue Shield Plan has just begun using a provider profiling program to select quality, cost-effective providers for its select PPO offered to Federal employees and its Capital Care HMO

network. This profiling system compares the practice patterns of D.C. area doctors. What is unique about this system is that it collects all the services ordered or performed by the doctor for a given episode of care including X-rays, lab tests, and hospital care.

So for a given illness the system captures total resources for that patient's episode of care. What you find is that someone who looks cost effective when you look at the price of office visits only may really be extraordinarily expensive when you add in all the other services such as X-rays, lab tests and referrals to specialists that doctor has ordered.

That concludes my remarks, and we look forward to working with Congress to make reform of our health care system a reality. I would just like to say in a final note, Mr. Chairman, with respect to the issue of solvency of the D.C. Plan we expect to have a formal announcement soon announcing an arrangement between the D.C. Plan and a group of Blue Cross/Blue Shield Plans to assure the solvency of the D.C. Plan and the security of the D.C. subscribers.

The CHAIRMAN. You are going to take on the Stark-McDermott Plan and insure us too?

[Laughter]

[The prepared statement of Ms. Fox follows:]

TESTIMONY OF
ALISSA FOX
EXECUTIVE DIRECTOR, CONGRESSIONAL RELATIONS
BLUE CROSS AND BLUE SHIELD ASSOCIATION
before the
Committee on the District of Columbia
Room 1310, Longworth House Office Building
Washington, D.C.
April 19, 1993

Mr. Chairman and members of the Committee, I am Alissa Fox, Executive Director of Congressional Relations of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 71 independent Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for nearly 70 million people. I appreciate the opportunity to testify today on health care reform options under consideration by Congress.

In my testimony today, I will speak briefly about the Blue Cross and Blue Shield of the National Capital Area's (BCBSNCA) role in providing coverage to District of Columbia residents. I will then turn to our analysis of the three health care reform options.

BCBSNCA provides coverage to 1.1 million subscribers in the Washington metropolitan area. Coverage is provided to approximately 420,000 federal employees and their families through the Federal Employee Health Benefit Program (FEHBP). Several different benefit packages are offered through the FEHBP, including an expanded preferred provider plan, BACE, for legislative branch employees. In addition, a substantial number of businesses -- large and small -- and individuals in D.C. are covered by BCBSNCA and its health maintenance organization, Capital Care.

I also would like to point out that the Blue Cross and Blue Shield Federal Employees Program had record gains in enrollment during the most recent open season. This success most likely is attributable to the program's new network of preferred provider physicians, hospitals and pharmacies. In addition, the program receives extremely high marks for customer satisfaction. A recent survey by the Gallup organization showed that members rate their customer service as 4.46 on a 5.0 scale.

I will turn now to a discussion of the three health care reform options you have outlined: single-payer, "play-or-pay" and managed competition approaches.

Single-Payer

Under a single-payer system, the federal government would provide coverage for everyone. The federal government would control total national spending on health care and set the health care budget for each area, including the District. The government would determine which medical services are covered and establish payment rates that providers would be required to accept as payment in full. This system could be financed by employer and employee payroll taxes as well as individual income taxes.

We oppose a single-payer approach for a number of reasons. First, health care decisions would be driven by budget pressures rather than sound public policy considerations. Whether the federal government would provide appropriate levels of high-quality care would be based on what the government would budget each year. As a result, financial support for hospitals and physicians would become an annual political decision that could lead to some of the consequences we have observed in other countries, including waiting lists, rationing and an inadequate investment in research and technology.

A single-payer system would depend on price controls and regulations that are incompatible with effective cost-containment. Setting arbitrary limits on how much the District could spend for health care or on the cost of a particular service fails to address the need to manage the use of health care services. Long-term costs cannot be contained unless there are incentives for individuals to change the way they use the health care system and for providers to change the way they practice medicine.

Finally, a single-payer system would stifle innovation and advances in technology. The government is historically slow to accept innovation. And technological research and advances in treating severe medical problems could be hampered under a system of price controls and heavy regulation.

"Play-or-Pay"

Under a "play-or-pay" approach, employers in the District and elsewhere would have a choice: to "play" by contributing to a health benefits package for their employees and dependents or to "pay" through additional payroll taxes to cover their employees under a government-run health care program.

We also have a number of concerns with this approach to health care reform. One fundamental concern with the "play-or-pay" structure is its inherent incentives for employers to increasingly abandon their role in providing benefits directly, and send their employees and their families to the public pool for coverage. Employers likely would weigh their particular health care needs to determine whether it would be less expensive to insure their employees through public pools. Because payroll taxes increase less quickly than health care costs, many employees eventually would move from private, employer-based coverage to government pools.

Experience in the Medicare program suggests that government cost controls would take the form of price controls on hospitals and physicians in the public pools. As noted earlier, we have serious concerns about proposals that rely on price controls to hold down costs because they do not provide any incentives to encourage hospitals and doctors to change their practice patterns and become more cost-effective.

Finally, we believe that a "play-or-pay" system could evolve into a single government-funded and government-operated national health program. Large employers who want to limit their own costs would have

an incentive to shift employees to public pools rather than pay for private insurance. Over time, this would lead to a a massive federal program as the major source of coverage for employees. We do not believe that the pool will be responsive to the needs of employees. The link between employers and employees in the current system provides for a degree of accountability and attention to individual employee needs that could not be sustained under a public program.

Managed Competition

We believe that the twin challenges of cost-control and access can best be brought about by a managed competition approach to health care reform coupled with a requirement that employers contribute to a basic set of benefits for employees and their dependents. Managed competition would create incentives to change behavior at all levels, making insurers, providers and consumers more price sensitive and quality conscious in delivering and purchasing health care services.

To implement managed competition, the inequities that exist in the insurance industry must be addressed first. We strongly support a top-to-bottom shake-up of the industry to eliminate competition based on selection of the best risks. Instead, insurers must compete on their ability to manage costs and provide high-quality service.

We envision a set of strict insurance reform standards that would apply to all insurers and self-funded entities that offer health care benefits. Only those insurers or self-funded plans that adhere to strict standards would be certified as Accountable Health Plans (AHPs). Insurers not willing to undertake the investment and make the commitment required to be an AHP could no longer be licensed to do business. It is particularly important to amend ERISA so that these reforms apply equally to both insured and self-funded entities, to assure that the whole market, and not just a segment of it, is reformed.

We place insurance reforms at the top of our list not only because we think it is the single most important element of health care reform but also because it could make a real difference in the lives of Americans almost immediately. We envision a market place where no one could be denied coverage because they were sick or had a high probability of getting sick; where no individual or group could be dropped from an insurance plan because of their claims history; where no one would have to stay in an unsatisfactory job because of fear that they wouldn't have health insurance -- or couldn't obtain health insurance -- from a future employer.

Indeed, we believe that if you use insurance market reform to lead the overall reform effort and couple these reforms with some changes in the federal tax code, you could achieve four of the five key goals of managed competition quite rapidly:

- Limiting the tax treatment of employer-provided health benefits would encourage and hasten the movement of consumers into more cost-effective delivery systems.

- Requiring all insurers to adopt an open enrollment standard would assure that any group or individual could purchase coverage from any AHP regardless of their health status.

- Requiring AHPs to offer standardized benefit packages and report on quality measurements would allow price and quality comparisons among different AHPs.

- Requiring AHPs to community rate with limited demographic adjustments would assure that high-cost groups do not have disproportionately higher premiums.

The fifth goal -- allowing individuals to choose their own AHP -- would require establishment of Health Insurance Purchasing Cooperatives (HIPCs) or some other similar entity in every area.

It will be difficult and time-consuming to establish these entities everywhere, and it doesn't make sense to delay the other necessary reforms -- and the cost savings they could be yielding -- until HIPCs are in place. In addition, this approach would eliminate the risk of making a reform strategy entirely dependent on a HIPC everywhere.

We think it would make more sense to put the first four elements of managed competition in place immediately: open enrollment, standardized benefit packages, community rating and changes in the tax treatment of employer-provided health benefits.

We then could gain experience with HIPCs through state projects aimed at small employers and/or individuals. We would recommend that these efforts be confined to businesses with fewer than 50 covered employees and dependents.

Such efforts are necessary prior to establishing the use of a HIPC in the District or similar areas because there are a number of unresolved issues that would arise with HIPCs. One key area of concern is the exact role of the HIPC. Some proposals envision them as a facilitator for small employers while others view them more as a government regulatory entity.

In addition, there are a number of design questions that are open. For example, would the HIPC cover the District only or also include surrounding counties? Would the HIPC cover both the District and Baltimore since they are part of a single new metropolitan statistical area? Would Members of Congress and their staffs who are currently covered under the Federal Employees Health Benefit Program be covered under the District HIPC? With what types of responsibilities would a HIPC be charged? If HIPCs have responsibility for regulating AHPs, how would regulation of AHPs that offered coverage both inside and outside of the HIPC be coordinated? Is it appropriate for a nongovernmental entity to have responsibility for collecting employer premium contributions? Who would qualify an AHP for participation in a HIPC and whose standards would it have to meet? These questions illustrate a few of the issues that would need to be resolved prior to full-scale implementation.

For these reasons, we believe that HIPCs must be carefully reviewed and tested before they are implemented in D.C. or similar areas.

Moreover, we would not support breaking up the FEHBP into local HIPC structures. FEHBP is very close to a managed competition model, and it is working well. It serves as a good model for very large, interstate employers because it treats all employees equally nationwide. It would be instructive to make refinements in the program (e.g., more standardized benefit packages or a risk adjustment mechanism) rather than to disassemble it in favor of a new HIPC structure.

The Blue Cross and Blue Shield Association's experience in FEHBP over the last 30 years has made us sensitive to some administrative problems that could arise with HIPCs. Currently, enrollment and disenrollment of participating individuals is a large challenge in the FEHBP even with only one large employer -- the federal government. HIPCs, however, would be responsible for managing the enrollment function for a multitude of employers. FEHBP also has no billing responsibilities, while HIPCs would be responsible for dealing with individuals and individual employees of small employers, which could be a significant task.

In addition, advocates of HIPCs acknowledge that a risk adjustor is needed to address adverse selection that would result from HIPC provisions, such as individual choice of coverage. There is no agreement, however, on how to design an effective risk adjustor. We have, in fact, recommended that the federal government experiment with model risk adjustors in the FEHBP.

Before closing, I would like to highlight an innovative new program of the BCBSNCA that is an example of the kind of initiative that would be developed under a managed competition approach. BCBSNCA uses a provider profiling program to select quality, cost-effective providers for its select preferred provider plan that currently is offered to federal employees through the Blue Cross and Blue Shield Federal Employee Program. This program focuses on assuring that the network initially selects these doctors, and then continues to monitor the practice patterns of these physicians over time.

The BCBSNCA profile program uses information from its database of over 20 to 30 million claim records to compare the practice patterns of physicians in the metropolitan area. The analysis includes all health care services recommended or performed by the doctor -- including inpatient and outpatient services, lab tests, diagnostic procedures and prescription drugs -- so that doctors can be evaluated on their total resource use for a patient's episode of care. We are initiating a continuous feedback program for physicians who have been recruited into the network so that they can see how their practice patterns compare to those of their peers. This gives them the opportunity to evaluate their own trends and adjust their patterns, if appropriate. BCBSNCA also uses profiling information to identify problem areas for providers that may need focused utilization review or quality management attention.

Conclusion

In conclusion, Mr. Chairman, we face a historic, strategic choice that will affect the character of our health care delivery system for decades to come. We are all tired of unrelenting health care cost increases. It is tempting to try to deal with the problem once and for all with a supposedly guaranteed solution.

But we are not going to deal with the problem once and for all. It will be with us for the foreseeable future, just as it will be for the Canadians and the Germans and the British. It will be with us because we will continue to seek ways to prolong life by finding more expensive ways to treat health care problems.

The question for this committee is not how to get rid of our health care problems, but how to manage them 10, 20, 30 years from now in a way that best promotes health and delivers the most value to the citizens of the District and the nation.

To do that, we need to change fundamentally the incentives for providing and financing health care services. We believe those changes can best be brought about by a managed competition approach to health care reform.

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The CHAIRMAN. Mr. Ott?

STATEMENT OF DR. JOHN E. OTT

Dr. OTT. Mr. Stark, Ms. Norton, and distinguished members of the House Committee on the District of Columbia, it is an honor to participate in these hearings on health care reform as it might impact on the District of Columbia. I would like to give you a little background on the George Washington University Health Plan, known as GWUHP.

The health plan is a nonprofit, federally qualified HMO which is operated by the George Washington University. The plan is 20 years old, so it antedates the Federal HMO Act. It is the oldest university-sponsored HMO offering health care services to the general public.

Our original objectives were to develop a model alternative delivery system which could be used to teach health professionals in an ambulatory setting, as well as to carry out research and provide service for our patients. The medical center even then recognized that there would be a need for many more primary care physicians and for an ambulatory practice.

The plan's affiliated clinical department also sponsors residency programs in primary care, general medicine and pediatrics. We are the only Washington-based plan which has been accredited both by the Joint Commission on the Accreditation of Health Care Organizations and the National Committee on Quality Assurance.

Our plan is predominately a group model plan serving the Metropolitan Washington area. We also have a smaller independent physician network. About 75 percent of our patients are in the group and 25 percent in the IPA model. We service about 38,000 members in the District of Columbia, of whom we estimate that about 23,000 are D.C. residents. About 31,000 receive their care in the group model and 7,000 in the D.C. IPA. Roughly 75 percent of our health plan hospitalizations are currently at District hospitals.

Most of the health plan reform principles currently under discussion have been practiced by the George Washington University Health Plan for the past 20 years. We specialize in the small group market. We pool the risk for all groups from 2 to 25 and 26 to 99, respectively, and also spread the risk for catastrophic cases over our entire membership. We community rate small groups and use the adjusted community rating for groups of more than 100. Once accepted all employees may join regardless of pre-existing conditions. No individual or group is dropped because of a catastrophic illness, and maximum premium increases are established to ensure that no one group receives an extremely high rate increase due to a catastrophic event.

These techniques result in a relatively stable premium increase from year to year and a rate which is not necessarily the cheapest but the most equitable for the largest number of patients. While rate increases are varied somewhat from year to year and group to group, the average rate increase for the past 9 years has been approximately 8 percent.

We have followed the discussion on health care reform with great interest. Unfortunately, many of the principles have not yet

been clearly elucidated, which makes it difficult to address some of the issues you have raised. Nonetheless, we will attempt to answer the questions as best we can based on the following assumptions.

There will be a standardized health benefit package available for all citizens regardless of their ability to pay. We would hope that this package would be relatively comprehensive and resemble that currently used by the Federal Employee Program. We would hope that it would have a prescription benefit and at least a prophylactic dental benefit for children.

Two areas which need specific clarification are transplant and mental health benefits. This package should minimize the abuses which are commonly seen in the small group insurance market, and the rules should be the same for all groups, including the self-insured groups, so as to minimize cost shifting and increased movement to self-insurance.

Some cost shifting will occur even if the proposed underinsured groups are incorporated into the insured pool. The standard plan should be tax deductible, both for the employer and the employee. The Government would pay the premium when funds are not available elsewhere, including people who lose their jobs, through a general tax.

Individuals or their employers could supplement the standard policy at an additional cost, if desired, which might be taxable. We need a national commission to determine at what point a new procedure should be covered by insurance. These decisions should be based on the cost effectiveness of the procedure as determined by independent scientists without vested interest in the procedure.

Tort reform is required, and binding arbitration is the preferred means of settling malpractice or coverage disputes.

As health care reform relates to the district, we do not believe there is any plan currently in existence that has the capacity or the financial resources to care for all medicaid and uninsured patients in the District. Therefore, we would suggest a pluralistic approach using a number of accountable health plans who are able to offer the standard benefit package rather than a single lowest bidder approach. The initial emphasis should be on improving the quality and access to care and emphasizing health prevention for District residents while managing costs, rather than obtaining the lowest possible bid.

In answer to the specific issues you have raised, the George Washington University Health Plan is interested in being an accountable health plan offering the standard benefit package. You might say we have been operating a HIPC for the past 20 years in some respects.

It is not possible to realistically estimate the monthly premium without a much more detailed analysis of the specific benefits being offered, the demographics of the District, and particularly of the currently uninsured or underinsured and the risk factors involved. Given the medical needs of the District and the presumed age of the population, it is quite possible that initially the cost of care may increase rather than decrease.

To be equitable and to minimize the risk of bankrupting accountable health plans, some of whom are likely to be underfinanced, it is essential to risk adjust the population. This could be done in a

number of ways: By carving out catastrophic cases; by carving out high-risk cases of one sort or another, and so forth. We are prepared to care for the high-risk populations, but they cannot realistically be cared for at the same premium unless we find some way to risk adjust or adverse selection, which is a critical issue.

It is also critical that self-insured groups bear their fair share of the adverse risk cost in the community. This is currently not the case.

We are not aware of any requirements placed on insurers by the Insurance Commissioner other than financial and solvency requirements, which are in the public's best interest, that limit the ability of insurers to contract for medicaid patients. There are some Federal rules that require both commercial and medicaid enrollment, which is a problem, and the fact that nonfederally qualified HMO's cannot obtain a lock unit at the present time is also a problem. These rules are well-intended, but they certainly inhibit participation.

We have expressed our interest in contracting for medicaid patients and are awaiting the HMO request for proposal which is currently under development.

If it were required that all medicaid patients should be hospitalized in the District, this would have no influence on our decision to participate. It should be understood, however, that no individual physician or no individual health plan would be able to contract and participate with all D.C. hospitals.

It is my understanding that the premium received by Chartered Health Plan is reasonably appropriate for AFDC-eligible medicaid enrollees. Dr. Bowles can, obviously, provide better information on this point than we can. We do not have the information required to determine whether Chartered's premium would be comparable to that for all medicaid enrollees, but it is highly unlikely that the premium would be adequate for the SSI patients, for AIDS patients, and for other selective high-risk groups.

No health plan currently operating in the District has geographically disparate sites in place to serve the entire population and staff or group model facilities. It would take 12 to 18 months to design and construct new facilities, and it is doubtful that any one plan has the financial resources to build sites in each ward. In addition to a large inner city facility that we have at the medical center, we do have a number of contracted IPA physicians in wards 1, 2, 3, 4, and 8. The medical center also provides support to the Zacchaeus Clinic, the Clinic de El Pueblo, and the Healthcare for the Homeless Program.

We would be least well prepared to service wards 6, 7 and 8 in the first year of the contract, but would be willing to undertake to contract with additional physicians in these areas where there is a mutual interest.

We do contract with the George Washington University Hospital. One of the major health care reform issues which has not yet been publicly discussed is how medical education will be supported. Such support, especially for primary care, is essential if we are going to improve the quality of care for our citizens.

If medicare or medicaid or other forms of medical care were made available to all underserved people in America tomorrow

there would not be enough physicians, physician's assistants or nurse practitioners to provide the care. That is a major issue which needs to be addressed, but it will be a long-term problem.

A question was raised about National Rehabilitation Hospital. We are currently negotiating a contract with that hospital, so I would not anticipate a problem in that regard.

We believe it would be a mistake to limit government support for the medicaid population to the lowest priced plan. Initial emphasis should be on prevention and improving the quality and access to care, while appropriately managing the cost. Contracting only with the cheapest bidder will result in cutting corners, skimming cream, and discouraging the provision of services.

Ultimately, the greatest saving will be made by those plans which provide continuity of care in an ambulatory setting while minimizing the use of emergency rooms and hospitals. While I would agree in the short run that if GWUHP's premium is $100 less than that of our competitors, we would get most of the business. However, if the premium differential is really that great, it is likely we have underestimated our risk and will be going bankrupt, and that serves no useful purpose for anyone.

I would like to emphasize that management of risk is the issue, not skimming the cream, if we really want to improve the quality of care. Currently 90 percent of our members we enroll each year would suggest that our members value our services. But we are not now and probably never will be the cheapest plan in town.

We do have limited numbers of independent practicing physicians in most parts of the city, and we would be willing to increase our recruiting efforts to assist in this issue. We do not have the financial resources to build facilities in each ward of the city. A pluralistic approach to this problem appears to be the best solution since patients and physicians are frequently associated with specific hospitals, and to the extent these relationships would be continued it is desirable from the health plan's point of view. Contracting with all District hospitals would be an administrative burden and would eliminate any plan's ability to negotiate price and other terms.

It is unclear to me how a HIPC would adjust for risk without making some sort of a financial adjustment. The financial adjustment could be a catastrophic cap, it could be an increase in the premium for selected patients or a carve-out of certain types of patients, but the net effect of this is still an increased payment. The only other approach I can think of is to randomly assign high-risk patients to all participants. But unless historical data for all patients is readily available, which I seriously doubt, I don't think the HIPC would have the data necessary to make random assignments.

Our particular group of providers would not be severely handicapped if we used only the District of Columbia hospitals and facilities. Patients living on the periphery of the city might be inconvenienced. While a District HIPC might have political appeal from an insurance point of view, it does increase the risk, because you are looking at a higher risk population and a relatively smaller population, and therefore the rates would be more unstable and unpredictable and are likely to be higher.

Therefore, we would suggest that if HIPC's are to be used that we have a larger SMSA-type HIPC, probably one which would extend in the Baltimore-Washington corridor and would go as far north as Frederick, Maryland, to the north, north or Baltimore, and east to Annapolis to the east, and south to Fredericksburg, Virginia, to the south, and west to Winchester. No one plan would necessarily be able to service the entire area.

A larger SMSA-type HIPC would necessitate the use of providers throughout the jurisdictions, but most care for District residents could still be provided in the District by using current Federal regulations or modifying them. Currently there is a rule which suggest that care should be available within 20 miles or 30 minutes driving time, and those regulations could be adjusted to meet their needs.

After the initial bid I would manage cost by managing care. After an initial surge in demand for services, which is highly likely, continuity of care and appropriate use of ambulatory facilities should decrease the use of emergency rooms and hospitalizations. Better patient education should improve patient compliance. The emphasis should be on managing the risk, not cutting the cost per se.

HMO management techniques such as selective contracting, utilization review, use of generic drugs, provider risk sharing, physician profiling, and outcome research—all are useful techniques and are equally appropriate to the medicaid population. I think it will take more time to educate patients about how to use the system more appropriately, and we may well need to address transportation problems in selected areas.

While some administrative savings are possible, the largest savings will come from reducing medical costs. In this regard we would like to suggest several things. One, we know that there is now pending a bill to provide all immunizations through Federal purchasing. If for some reason this bill does not pass, we would still like to recommend that all immunizations be provided through purchase by the Public Health Department and then redistribution to the plans, which would result in a significant saving.

We believe that medicaid could negotiate the hospital rates and carve out this portion, and that they would be able to get a better rate than any individual plan would be able to get with specific hospitals. The rates I think may need an upward adjustment, however.

Finally, we would like to suggest that a regulation be passed that if a patient in this program is hospitalized at a nonparticipating hospital that the payment to that hospital would be the same as if it were a participating hospital. As it now stands, if a patient is admitted to a nonparticipating hospital, they pay full charges.

The capacity to expand the system is a function of capital, time, and ability to contract with qualified providers. With the capacity we now have, we could accommodate 2,000 or 3,000 patients. We could probably increase that to 5,000 in the first year if needed.

Rating, I think, is really impossible to discuss without more specific and detailed information, but it is critical that if we are going to have a true community rate that the risk has to be spread across the entire population, including the self-insured.

It is difficult for health plans to know how much cost shifting occurs between medicare and private pay. Hospitals are in a better position to answer that question. It would be a mistake, however, to assume there would be no cost shifting with this program. In Maryland, which is an all-payer State, the cost shifting is estimated to be approximately $300 per admission. If the standard benefit package were a modest one, the cost shifting would be greater.

There are a number of administrative expenses which could be saved. One is to have a unified billing and collection through a HIPC. Individual marketing is very expensive; individual monthly billing is very expensive, and if that could be avoided it would certainly be to everyone's advantage.

A single national source for physician credentialing would be very helpful as it is a very time consuming and very expensive procedure when primary credentialing is required for each plan. Mandated internal quality assurance, quality improvement programs with decreased external review and increased provider risk sharing would be helpful, as would uniform billing forms and electronic data submission of claims. I do not have sufficient data to estimate these savings, but they are potentially significant.

Mr. McDermott [presiding]. I wonder if maybe, since your testimony appears to be written, you could just submit the rest of it and maybe summarize so we can move on.

Dr. Ott. Actually, I have essentially completed the testimony. We look forward to working with the committee, and we particularly look forward to working with the District to improve the quality of access to care for our citizens.

Thank you.

[The prepared statement of Dr. Ott follows:]

Statement of John E. Ott, M.D.
Executive Director and CEO
The George Washington University Health Plan
before
Committee on the District of Columbia
U.S. House of Representatives
April 19, 1993

Mr. Stark, Mrs. Norton and distinguished members of the House Committee on the District of Columbia. It is an honor to participate in this hearing on health care reform as it might impact on the District of Columbia. Before I address the issues, I would like to first take a few moments to tell you about The George Washington University Health Plan (GWUHP).

The Health Plan is a non-profit federally qualified HMO which is operated by the George Washington University. The Plan, is twenty-years old and preceded the federal HMO Act. It is the oldest University sponsored HMO offering health care services to the general public. The University's original objectives for starting the Health Plan were to develop a model alternative delivery system which could be used to teach health professional students in an ambulatory setting and to carry out health care delivery research as well as provide quality patient care. The Medical Center realized that there should be more ambulatory teaching as future health professionals would provide most health care services on an outpatient basis.

The Plan's affiliated clinical department also sponsor residency programs in primary care, general medicine and pediatrics. GWUHP is nationally recognized for its service, education and research activities. More than two hundred publications or presentations on quality, cost-effectiveness, and health services research have been based on work carried out at the Plan. GWUHP is the only Washington based Plan which has been accredited by the JCAHO and NCQA.

The Plan is predominately a group model plan serving the Metropolitan Washington area. We have also developed an independent physician network. About 75% of our members are in our group model and about 25% in our IPA. We have approximately 60,000 members. We estimate that 23,000 of the 38,000 members who receive their care in the District of Columbia are District residents. Roughly 31,000 receive their care in the D.C. Group model and 7,000 are members of the D.C. IPA. Approximately 22,000 of our members receive their care in the suburban Maryland and Virginia counties. Roughly 75% of all health plan hospitalizations are at District hospitals - predominately the George Washington University Hospital and Children's Hospital.

Many of the Health Plan Reform principles currently under discussion have been practiced by The George Washington University Health Plan for the past 20 years. We specialize in the small group market. We pool the risk for all groups from 2-25 and 26-99 respectively and also spread the risk for catastrophic cases over our entire membership. We community rate small groups and use adjusted community rating for groups of more than 100. Once accepted, all employees of the group may join, regardless of pre-existing conditions. No individual or group is dropped because of their members' developing a catastrophic illness, and maximum limits for premium increases are established to insure that no one group receives an extremely high rate increase due to a catastrophic illness. These techniques result in a relatively stable premium increases from year to year and a rate which is not necessarily the cheapest, but the most equitable rate for the largest number of patients. While rate increases vary somewhat from group to group (type of plan chosen) the average rate increase per year for the last nine years has been approximately 8%.

We have followed the discussion on health care reform with great interest. Unfortunately many of the principles related to health care reform have not been clearly elucidated which make it difficult to address some of the issues you have raised. Nonetheless, we will attempt to answer the questions where possible based on the following assumptions:

1) A standardized health benefit package should be available to all citizens regardless of their ability to pay. The package should be relatively comprehensive resembling the FEHBP comprehensive benefits with a prescription benefit and preferably with at least a prophylactic dental benefit for children. Transplant and mental health benefits must be clearly spelled out and standardized.

2) The package should minimize abuses commonly seen in the small group insurance market and the rules should be the same for all groups, including self-insured groups, so as to minimize cost-shifting and increased movement to self-insurance to avoid paying for mandated benefits, premium taxes, shared catastrophic risk, etc.

3) Some cost-shifting will still occur even if Medicaid, Medicare and uninsured legal residents are included in the insured pool.

4) The standard plan should be tax deductible benefits for employers and employees. The government would pay the premium when funds are not available elsewhere, including people who lose their jobs, through a general tax paid by all working people.

5) Individuals or their employers could supplement the standard policy at an additional cost if desired, which might be taxable.

6) A National Commission should determine at what point a new procedure should be covered by insurance payments. These decisions should be based on cost-effectiveness of the procedure as determined by independent scientists without vested interests in the procedure.

7) Tort reform is required and binding arbitration is the preferred means of settling malpractice or coverage disputes.

8) As health care reform relates to the District, no one health plan has the capacity or resources to care for all Medicaid and uninsured patients; therefore a pluralistic approach using a number of accountable health plans (AHP) who can offer the standard benefit package is the preferred approach to a single "lowest bidder".

9) The initial emphasis should be improving the quality and access of care and emphasizing health prevention for District residents while managing costs rather than to obtaining the lowest initial price.

<u>On Managed Competition</u>

1. If the entire District of Columbia were a HIPC and, for sake of argument, all 600,000 residents were required to be in it, would you bid to be an AHP offering the basic benefit package?

The George Washington University is interested in being an AHP offering the basic (standard) benefit package to a D.C. HIPC. You might say we have been functioning as a HIPC for the past 20 years.

2. Roughly, what do you estimate your monthly premium would be compared to your average monthly premium now?

It is not possible to estimate the monthly premium without a much more detailed analysis of the specific benefits offered, the demographics of the District (and particularly of the currently under-insured), and the risk factors. Given the current medical needs of the District and the presumed age of the population, it is quite possible that initially the cost of providing quality care would increase rather than decrease. To be equitable and to minimize the risk of bankrupting AHPs some of whom are likely to be underfinanced, it is essential to risk adjust the population. This could be done by carving out catastrophic cases, high risk care, such as mental

health and AIDS patients, etc. We are fully prepared to care for high risk patients but the payment for them needs to be different to protect any AHP from undue adverse risk selection or insolvency.

It is also critical that self-insured groups bear their fair share of the adverse risk in the community. (By definition large self-insured groups are likely to be healthier than the average. Currently self-insured groups do not contribute to charity care, avoid mandated benefits and premium taxes).

3. Currently, only Chartered Health Plan offers insurance to 16,000 of the District's 100,000+ Medicaid population -- an IPA model HMO. Are there requirements placed on insurers by the Insurance Commissioner that limits the ability or interest of insurers to contract for Medicaid enrollees?

If similar restrictions were extended to all AHPs -- like a requirement on insurers to contract with District hospitals -- how would this influence your decision as to whether to participate in a DC HIPC?

We are not aware of any requirements placed on insurers by the Insurance Commissioner other than financial insolvency requirements, which are in the public's best interests, that limit the ability of insurers to contract for Medicaid patients. The federal rule requiring both commercial and Medicaid enrollees in the same plan as well as one which prohibits locked-in enrollment for non-federally qualified plans are well intended but inhibitory. We have experienced our interest in contracting for Medicaid patients and are awaiting the revised HMO request for proposal (RFP) from the D.C. Medicaid Program. Hopefully it will be available in July and will encourage Medicaid enrollment.

If the D.C. Medicaid Chief required that, except in emergencies, all Medicaid patients would be hospitalized in the District, this would have no influence on our decision to participate in a D.C. HIPC. It should be understood, however, that no individual physician or health plan could be expected to contract with all D.C. hospitals.

4. My understanding is that Chartered Health Plan enrolles only the AFDC-eligible Medicaid enrollees. AFDC-Medicaid enrollees make up roughly one-half of the total Medicaid population in the District. How does the amount of the premium received by Charter for Medicaid enrollees compare to the average cost of all Medicaid enrollees?:

Would enrollment of the non-AFDC eligible Medicaid population require adjustment to the premium currently received by Chartered?

It is my understanding that the premium received by Charter Health Plan is reasonably appropriate for AFDC eligible Medicaid enrollees. We do not have the information required to determine whether Charter's premium would be comparable to that for all Medicaid enrollees. It is highly unlikely the premium is adequate for the SSI or the AIDS population and therefore a risk adjusted premium would likely be required. Another possibility would be to establish catastrophic caps for individual patients or provide carve-outs for high risk problems.

5. Do you have the facilities currently in place to serve the entire population in an HMO? If not, how long would it take you to get them in place?

No health plan currently operating in the District has geographically disparate sites in place to serve the entire population in staff or group model facilities. It would take 12-18 months to design and construct new facilities and it is doubtful that any one plan has the financial resources to build sites in each ward. In addition to a large inner city facility based at the Medical Center, we do have contracted IPA physicians in Wards I, II, III, IV, and VIII. The Medical Center also supports the Zaccheus Clinic, the Clinic del Pueblo and the Care for the Homeless. We would be least prepared to serve Wards VI, VII and VIII in the first year of the contract. It takes a minimum of three months to fully credential each of our highly selected independent

physician contractors and it would take 1-2 years to significantly increase the number of contracting physicians.

6. Would you contract with any of the City's teaching hospitals? And, if not, what would you expect to happen to teaching hospitals? Would you contract with National Rehabilitation Hospital for rehabilitation services?

We do contract with The George Washington University Hospital (one of the major teaching hospitals). One of the major health care reform issues which has not yet been publicly discussed is how medical education would be supported. Such support, especially support of primary care, is essential if we are to meet the needs of our citizens. If medical care were made available to all under-served people in America tomorrow, there would not be enough physicians, physician's assistants or nurse practitioners to provide the care. We are currently negotiating a contract with National Rehabilitation Hospital.

7. Under managed competition as it has been defined, government support for the Medicaid population would be limited to the price of the lowest priced plan. Assume you are the lowest priced AHP, and for whatever reason, all the other AHPs bid $100 more per month/$1200 per year. Do you agree that almost immediately you would be the AHP used by the current Medicaid population and the poor and near-poor?

It would be a mistake to limit government support for the Medicaid population to the lowest priced plan. The initial emphasis should be on prevention and improving the quality and access of care while appropriately managing the costs. Contracting only with the cheapest bidder will result in cutting corners, skimming the cream, discouraging the provision of services, etc. Ultimately the greatest savings will be made by those plans who provide continuity of care in the ambulatory setting while minimizing inappropriate use of hospitals and emergency rooms. While I would agree in the short run that if GWUHP's premium is $100 a month less than that of our competitors, we would get most of the business. However, if the premium differential is that great, it is likely that we have underestimated the risk and our plan will become insolvent. We need to emphasize the management of risk, not skimming the cream, if we truly wish to improve the quality of care for our population. The fact that 90% of our members re-enroll each year, indicates our members value our services, but we are not and never will be the cheapest plan in town.

8. Are you prepared to provide primary care and other services in the areas of the city where most of the poorer residents are located. If not, when could you?

We have limited numbers of independent participating physicians in most parts of the City. We are willing to increase our recruiting efforts of qualified physicians in under represented areas. We do not have the financial resources to build facilities in each Ward of the City. A pluralistic approach to this problem is the best solution since patients and physicians are frequently associated with specific hospitals and to the extent these relationships can be continued it is desirable from the Health Plan's point of view. Contracting with all District hospitals would be an administrative burden and would eliminate our ability to negotiate price.

9. A proposed function of the HIPC is to make risk adjustments to protect against adverse selection in any one plan. Do you believe that if you were the lowest priced AHP in an area where the poor might be concentrated, that the Government would be able to sufficiently risk adjust your contract so that you would be able to survive without an upward adjustment of monthly premium?

It is unclear to me how the HIPC would risk adjust to protect against adverse selection in any one plan without making a financial adjustment. That financial adjustment could be a catastrophic cap, an increase in premium, or a carve-out of certain types of patients, but the net effect of this is an increased payment. The only other approach I can think of is to randomly assign high risk patients to all participants. Unless historical claims data for all patients would be readily available, I doubt that the HIPC would have the data necessary to make random assignments.

10. How would a D.C. HIPC/AHP work across state lines? In other words, would your network of providers be moderately or severely hurt if you had to use providers just in DC?

Our particular network of providers would not be severely handicapped if you had to use providers only in the District of Columbia. Patients living on the periphery of the City might be inconvenienced. While a District HIPC might have political appeal, from an insurance point of view it increases the risk and therefore the premiums for the District.

11. Do you believe a Capital Area HIPC could only work if it covered a larger SMSA-type area? Where would you draw the line?

The rates would be more stable and the cost for the District would be lower if the risk were spread over a larger risk pool covering a larger SMSA type area. I would suggest the expanded Baltimore Washington SMSA including Frederick, Maryland to the North; North of Baltimore and East to Annapolis; South to Fredericksburg, Virginia; and West to Winchester. No one plan would necessarily be able to service the entire area.

A larger SMSA HIPC would necessitate the use of providers throughout the jurisdictions, but most care for District residents could be provided in the District by using the current Federal HMO access rules e.g. care should be available within 20 miles or 30 minutes driving time, or some variation thereof.

12. Would you describe how you would hold down costs after the initial bid?

After the initial bid, I would manage costs by managing care. After an initial surge in demand for services, continuity of care and appropriate use of ambulatory facilities should decrease use of emergency rooms and hospitalizations. Better patient education should improve patient compliance. The emphasis should be on managing the risk, not cutting the price by skimming the cream. HMO management technique such as selective contracting, utilization review, use of generic drugs and MAAC pricing, provider risk sharing, physician profiling and outcome research, etc. -- are equally appropriate for the Medicaid population. But more time will be required to educate patients about how to use the system more appropriately. Transportation problems will also need to be addressed.

While some administrative savings are possible, the largest savings will come from reducing medical costs. These specific suggestions have been made by us to the Medicaid Administration which would assist cost control:

1) Provide all immunizations to the plans through Health Department purchases rather than have Plan doctors pay for them.

2) Directly negotiate hospital rates and carve-out this portion. Medicaid rates need to be increased but Medicaid will be able to negotiate a better rate than any Plan.

3) Pass a regulation that if a patient in this population is hospitalized at a non-contracting hospital, its payment will not exceed payment made to contracting hospitals.

<u>On All-Payor Pay-or Play</u>

1. Again, questions on capacity. The uninsured use about 30% less medical care than the insured. If everyone in the District had access to an enhanced Medicare package of benefits, either through their workplace or thorough a publicly financed plan, how many of the (1) 110,000 Medicaid persons, and (2) 120,000 currently uninsured would you be able to enroll in the first year?

Capacity to expand the system is a function of capital, time, and ability to contract with qualified providers. With the capacity we now have we could accommodate 2-3,000 patient in the first year. Assuming the rates were sufficient to be of interest to our contracting IPA physicians the capacity could probably be increased to 5,000 the first year.

2. Question on Cost: If you had an open enrollment, community-rated enhanced Medicare policy available to every District resident, what would you price it at?
How would the premiums differ between group and individual policies?
How does that premium compare to your current mix of policies?

Unfortunately there is no data available to estimate a community rate for an enhanced Medicare policy for every District resident. The benefit package, copayments and or deductibles, demographics, risk pool, experience, etc are unknown, and it is not clear whether the current AAPCC for the District is applicable to those who are currently uninsured. It probably is not.

If a true community rate is spread among the entire risk pool (including the self-insured) the primary difference in rates between group and individual policies would be the increased administrative costs of individual billing and collection which would have to be paid by the HIPC or by the Plan. How that premium difference would compare to our current mix of policies would depend on whether or not the self-insured were included in the pool.

3. This plan would be an all-payor system and would eventually use Medicare methodology to control charges. Today, how much cost shifting in percentage occurs between Medicare and private pay?

If you had Medicare payment rates for everyone and no more bad debt, uncompensated care and Medicaid payment rates, how much would you gain?

It is difficult for a health plan to know how much cost-shifting occurs between Medicare and private pay. Hospitals can better answer that question. It would be a mistake, however, to assume that if Medicare and Medicaid and the uninsured were included in an all payor system that cost-shifting would disappear. In Maryland, which is an all payor State, the cost-shifting is approximately $300 per admission. If the standard benefit package is not a comprehensive one, the cost-shifting would be greater. Unless insurance is provided for immigrants and aliens, which I do not believe is contemplated, there would still be uncompensated care in the District -- even if there were Medicare payment rates for everyone and no more bad debt, normal uncompensated care and Medicaid payment rates. Furthermore, few if any District hospitals are currently breaking even, on current, let alone proposed Medicare payment rates.

<u>On Single Payor Medicare-for-All (for HMOs)</u>

1. Again, questions on capacity. I assume your answer is the same as the answer to the Medicare for All question: The uninsured use about 30% less medical care than the insured. If everyone in the District had access to an enhanced Medicare package of benefits through a public insurance plan, how many of the (1) 110,000 Medicaid persons, and (2) 120,000 currently uninsured would you be able to enroll in the first year? In the second year?

Having a single payor has not been proven to save administrative expenses because published "evidence" usually compares apples and oranges. Dr. Elders recently pointed out that the federal government spends 18 cents in administrative costs for every 3 cents it pays to tobacco farmers and 79 cents to pay for the medical care related to tobacco use. I do not consider this example of a single payor administrative expense to be efficient or good management of risk. Medicare administrative expense is often cited to be 3%. That is misleading because Medicare pays claims but does not manage risk very well. In addition the cost of hospital bills related to the types of illness and length of stay of geriatric patients is so large that 3% is a lot of money compared with 3% of the average contracted hospital bill.

2. Having one payor would save you some administrative expense. Estimate of how much?

Administrative expenses could be reduced by:

1) unified billing and collection through HIPC;

2) a single national source for primary credentialling of providers; which would greatly reduce duplication of effort and expense;

3) mandated internal QA/AI programs with decreased external review and increased provider risk sharing;

4) uniform billing forms and electronic data submission.

There is insufficient data to estimate the savings but it is potentially significant.

3. Could you comment on how your bid to provide capitated services might differ under this system as compared to the other two? Would it be higher or lower?

Whether capitated services under a single payor system would differ would depend on the regulatory and administrative requirements which were imposed. IF HICFA 1500 forms for each encounter and external reviews, detailed documentation, cost reports etc were required there may be little or no savings.

CONCLUSION

Thank you for the opportunity to testify on these issues. We look forward to working with this committee as work on Health Care Reform proceeds. We particularly look forward to working with the District to improve the quality of access of care for our citizens. I would be happy to answer any questions.

Mr. McDERMOTT. Mr. Bowles.

STATEMENT OF ROBERT L. BOWLES, JR.

Mr. BOWLES. Good morning, Chairman Stark, Ms. Norton, and Mr. McDermott. I am Robert L. Bowles, Jr., president and chief executive officer of D.C. Chartered Health Plan, Inc., and it is my pleasure to appear at this hearing on health care reform and have the opportunity to offer my comments on national health insurance and the implication for residents of the District of Columbia.

As my general statement, I have chosen to give an overview of health care reform needs that face urban centered managed care plans serving the medicaid population and to depict an urban centered model, D.C. Chartered Health Plan, Inc.

Following are some observations for your consideration in addressing urban interests and general issues that currently face urban centered managed care plans serving medicaid populations. There clearly are three major issues confronting health care reform today. These issues are the clinical management of medical care services, the operational management of health care delivery systems, and the economic impact.

In recognizing these issues, we in the public and private sector must advance a suggestion for health care reform that, one, emphasizes improved clinical management that advances quality of care; two, improve operational management that both advances and promotes access to quality care and services, prevention and health maintenance; and, three, cost containment by promoting competition in business efficiency for insurers in such improved comprehensive health care delivery systems.

The current issues that urban centered managed care plans serve in medicaid population bases are: One, the public expectation; what does the public expect? two, increasing health care costs; and, three, improved operational efficiency and organizational effectiveness in a manner that allows us to promote positively access, quality, cost containment, and accountability.

Urban centered managed care plans also face challenges that are somewhat different from traditional commercial operations, particularly in the following areas: Providing significant outreach through services through marketing and educational empowerment, member services, and transportation; two, offering solutions that are sensitive to urban populations; and, three, stressing health education, prevention, and health promotion.

We believe that we must do several things in addition to that: That we should operate in the traditional form of an HMO, and in this traditional form HMO's first of all stress the provision of comprehensive health and medical care; two, promote through design access to care; three, stress prevention and health maintenance and treatment services; and, four, maintain standards for procedures to monitor the level of quality of care; and, five, they are designed to achieve operational efficiency and organizational effectiveness.

In terms of an urban centered model, D.C. Chartered Health Plan, you might say, is ahead of health care reform because in its founding vision it was founded to provide care to diverse popula-

tions. To enhance our philosophical approach to managed care. Chartered has established a definitive IPA model HMO. In this regard, Chartered has retained, through contractual agreements with over 223 primary care and specialist physicians, the comprehensive health care delivery system that we operate today, has 58 primary care sites and over 71 primary care physicians practicing in those sites.

Through Chartered's health care delivery system, we have the ability to enhance our commitment to access, quality care, health education and promotion, and accountability as a managed care operation. I would like to say also that last spring we recognized the need to have more primary care physicians in southeast Washington, DC., and on our own we established a wholly owned subsidiary to contract and bring in new physicians, and, in this case, pediatricians, to operate in newly established sites, so we have already established a subsidiary to bring on new primary care sites to work with our existing IPA model.

We believe that, first of all, empowerment of the community based—community based physicians that we have now, and thus is was our founding of the IPA model. Currently I am in negotiations to address more needs in southeast Washington, DC., in terms of wards 7 and 8. What I would like to say on the record is, currently we are planning to establish two major primary care sites, one in ward 7 and one in ward 8. Each of these two sites will complement our current 71 primary-care physicians, but each of these two sites currently have the capability in the fall of taking care of the needs, medical service needs, of approximately 15,000-plus enrollees.

So, therefore, our plans are that we will have by the fall of this year in place two major primary care centers that could address the needs of approximately an additional 30,000 medicaid recipients in southeast Washington, DC.

[The prepared statement of Mr. Bowles with attachment follows:]

Statement by

Robert L. Bowles, Jr., D.B.A.
President and Chief Executive Officer

at the Hearing of the

Committee on the District of Columbia

on

Health Reform

Monday, April 19, 1993
10:00 a.m.

Longworth House Office Building
Room 1310A

Chairman Stark, Committee members, and panel members, it is my pleasure to appear at this hearing on health care reform and have the opportunity to offer my comments on national health insurance reform and the implications for residents of the District of Columbia. As my general statement, I have chosen to give an overview of health care reform needs that face urban-centered managed care plans serving the Medicaid population and to depict an urban-centered model, D.C. Chartered Health Plan, Inc.

Following are some observations for your consideration in addressing urban interest and general issues that currently face urban-centered managed care plans serving Medicaid populations.

There clearly are three major issues confronting health care reform today. These issues are:

1. The Clinical management of medical care services.

2. The Operational management of health care delivery systems.

3. The Economic impact.

D.C. CHARTERED HEALTH PLAN, INC.
820 First Street, N E • Suite LL100 • Washington, D C 20002-4205 • Tel: (202) 408-4710 • FAX: (202) 408-4730

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In recognizing these issues, we, in the public and private sector, must advance the suggestion for health care reform that emphasizes:

1. Improved clinical management that advances quality care.

2. Improved operational management that both advances and promotes access to quality care and services, prevention, and health maintenance.

3. Cost containment by promoting competition and business efficiency for insurers in such an improved comprehensive health care delivery system.

The current issues that urban-centered managed care plans serving Medicaid populations face are:

1. **The Public Expectation** (what people perceive is what they believe to exist). This has tremendous impact on the reputation and creditability of a managed care plan.

2. **Increasing Health Care Costs**. This has a tremendous impact on the relationship that managed care plans have with the state in an attempt to assist the state in containing costs.

3. **Increasing Operational Efficiency and Organizational Effectiveness** in a manner that allows us to positively address the problems of:

    - Access
    - Quality
    - Cost Containment
    - Accountability

From a commitment relative to the public good perspective, urban-centered managed care organizations must perform in a manner that empowers their enrolled populations with **Awareness** and **Knowledge** about the benefits of being enrolled members, and also in a manner that results in enhancing their dignity as a result of such members' experience with such managed care organizations.

Urban-centered Medicaid managed care plans also face challenges that are somewhat different from traditional commercial operations' particularly in the following three areas:

1. Providing significant outreach (marketing/educational empowerment; member services; and transportation).

2. Offering solutions that are sensitive to urban populations.

3. Stressing health education, prevention, and health promotion.

In urban-centered Medicaid operations, we know that **Quality** starts with marketing. What we tell people must prepare them for their experience with us (we must verify our marketing activities through our internal quality performance evaluations).

More importantly, in urban-centered managed care plans, we must be prepared to establish good and efficient management operations and good internal quality assurance programs.

A number of our operational areas must be enhanced in a manner that supports our health plans' goal of **Total Quality Management**. First of all we must take on the challenge of optimizing operational efficiency and organizational effectiveness with a total commitment to be high-spirited, service-oriented companies in which significant steps toward additional outreach efforts have been taken.

Appreciating the diverse population that we serve and their needs, we need Maternal/Child Outreach Representatives who work in the community in an attempt to inform, educate and facilitate non-compliant pregnant women in obtaining prenatal care. At the same time, our Health Education Departments must conduct massive educational outreach efforts addressing those areas where the needs are the most. We know that we must work directly with hospitals and other providers, as a part of our effort in a manner that enables us to make decisions about support services required for families prior to the services actually being needed.

We must be sensitive to and have an appreciation for the challenge that we face in order to provide accessible, affordable, high-quality health care services to our urban-centered populations.

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As it pertains to urban-centered populations, we recognize that a significant amount of the health care services are paid for by Medicaid funds and that we are in an era where cost containment is an absolute reality. So, therefore, we must appreciate the dynamics of efficiency and effectiveness of the managed care model, which will put us on the leading edge of not only providing the solutions that address the needs of our urban-centered populations, but which will also allow us to be competitive for servicing previously underserved populations.

Lastly, we must observe and demonstrate our appreciation that an important part of health care delivery is managed care in its traditional form. In its traditional form, managed care--

1. stresses the provision of comprehensive health and medical care;

2. promotes, through design, access to health care;

3. stresses prevention and health maintenance and treatment services;

4. maintains standards for procedures to monitor the level of quality of care provided;

5. is designed to achieve operational efficiency and organizational effectiveness.

An Urban-Centered Managed Care Model

D.C. Chartered Health Plan, Inc.

D.C. Chartered Health Plan, Inc. is a comprehensive system of high-quality health and medical care provided by experienced professionals committed to our members dignity and well being. We provide health maintenance and treatment services to small and large business group employers, union and association members, and low-income and government-assisted populations.

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Chartered Health Plan's (Chartered) **Concept*** is "A Systemic Approach To Illness Prevention and Delivery of Comprehensive Health Services." Our **Goal** is to provide Quality Health Services. Our **Methodology: The Health Maintenance Organization** is a four-way arrangement between the management company, providers, enrollees, and financing. Our desired **Outcomes** are that we have an informed consumer as a client/member; that we achieve operational efficiency; and that we effect the provision of quality health care services in a fiscally-responsible manner.

To enhance our philosophical approach to managed care, Chartered has established a definitive IPA-model HMO. In this regard, Chartered has retained, through contractual agreements with over 223 primary care and specialist physicians. The comprehensive health care delivery system established by Chartered gives it a capability of 58 different primary care sites for our members' access to their personal physician for primary care services. Through Chartered's health care system design, Chartered's ability has enhanced its commitment to Access, Quality Care, Health Education and Promotion, and Accountability as a managed care organization.

Chartered's Purpose is to provide health care under a managed care framework. Our objectives are: (1) to provide broad benefits with little cost sharing (co-pay); (2) to specifically address the public health problems of Infant Mortality; Teen Pregnancy; Hypertension; Substance Abuse; and Diabetes; and (3) to enhance the dignity of the human spirit (causing people to feel good about themselves as a result of their experience with Chartered Health Plan).

Recognizing our desire to enhance our already existing efforts toward carrying out an effective immunization program, for our members, in January 1991, Chartered Health Plan began the direct purchase of vaccines and began a personal distribution of such vaccines to our primary care physician offices so that we would first increase the effectiveness of our immunization program and secondly through our oversight,more closely monitor the quality of our immunization program. This program will be discussed later with our Corporate Medical Director.

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*Originally developed by Bowles in 1984. (See Linkages Chart Attached.)

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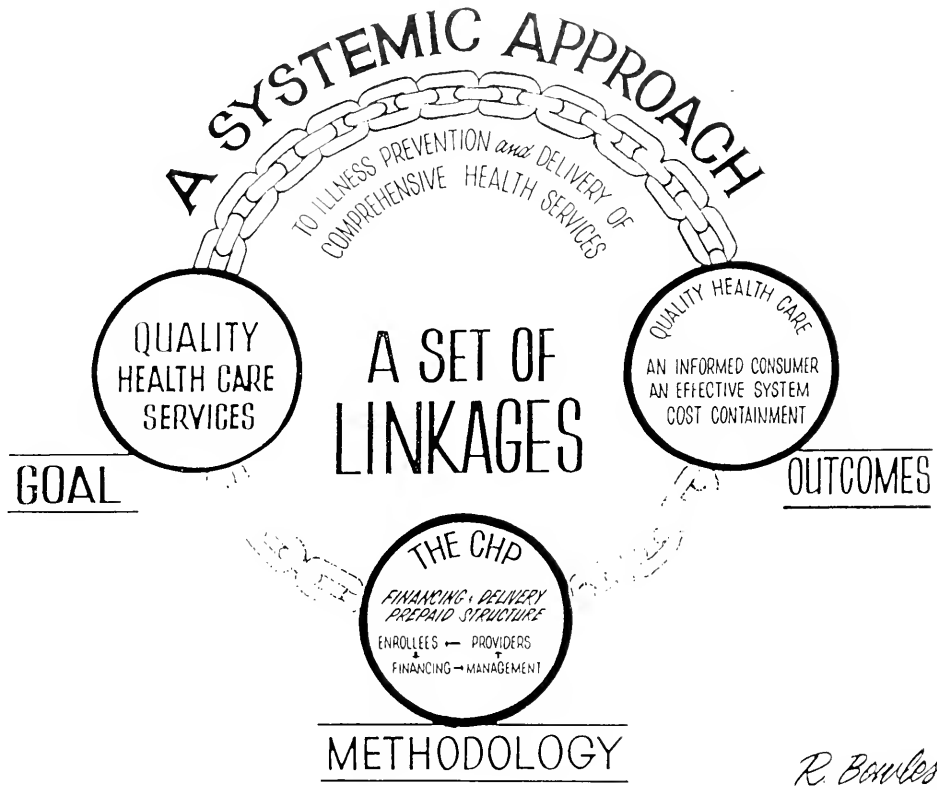
Appreciating the diverse population that we serve and their needs, in November 1991 we established a staff position in our Utilization Review Department entitled Maternal/Child Outreach Representative. This person works in the community in an attempt to inform, educate and facilitate non-compliant pregnant women in obtaining prenatal care. At the same time, our Health Education Department has conducted a massive educational outreach effort toward our total member population with emphasis on our prenatal care program and inviting all pregnant members to contact us for immediate assistance. The effort was facilitated by a very appealing mailer. Lastly, in December 1991 we allocated a staffing requirement for a Nurse Case Manager who would enhance the efforts of our in-home Utilization Review Nurse Coordinators by working directly with hospitals and other providers, as a part of our company effort, that enables us to make decisions about support services required for families prior to the services actually being needed.

D.C. Chartered Health Plan, Inc. prides itself on providing quality managed care services to its members who belong to our three benefits plans: Chartered AFDC Medicaid Program; Chartered Select (high option); and Chartered Choice (low option). We are a professional "service"-oriented company seeking at all times to be of service to our members, our providers, and their respective office staffs. Seeking proactive strategic solutions is a continuing objective of our company.

Of utmost importance for us as a provider organization, is to be sensitive to and have an appreciation for the challenge that we face in order to provide accessible, affordable, high-quality health care services to our members in general, and more specifically, to inner-city populations. It is my belief that if we appreciate the dynamics of efficiency and effectiveness of the Chartered Health Plan managed care model, we will be on the leading edge of not only providing the solutions that address the needs of our inner-city which we, at D.C. Chartered Health Plan, Inc. so very much embrace, but also our concept allows us to be competitive for servicing previously underserved populations such as the working poor and small to medium-sized businesses who can afford certain levels of health insurance premiums but cannot afford expensive high benefit option premiums.

By being able to address the aforementioned diverse populations Chartered Health Plan is considered a broadly defined "market niche" managed care Plan that again is focusing on quality, accessible, and affordable services for the communities that we serve.


A SYSTEMIC APPROACH
TO ILLNESS PREVENTION and DELIVERY OF COMPREHENSIVE HEALTH SERVICES
QUALITY HEALTH CARE SERVICES
A SET OF LINKAGES
QUALITY HEALTH CARE
AN INFORMED CONSUMER
AN EFFECTIVE SYSTEM
COST CONTAINMENT
GOAL
OUTCOMES
THE CHP
FINANCING + DELIVERY PREPAID STRUCTURE
ENROLLEES ⟷ PROVIDERS
FINANCING → MANAGEMENT
METHODOLOGY
R. Bowles

Mr. McDERMOTT. Congresswoman Norton will inquire.

Ms. NORTON. Ms. Fox, some of us who grew up on Blue Cross as if it were the functional equivalent of the Good Housekeeping Seal of Approval in health care have been dismayed at the financial difficulty of some of the plans in this area and around the country, some of which came, it would appear, from excesses and poor management. Do you believe that the President's plan that he is about to submit should contain provisions that keep plans like Blue Cross from getting into the kind of difficulty widely reported? If so, what kind of provisions do you think would be helpful in keeping those problems from recurring?

Ms. FOX. First of all, there have been mistakes that have been made in some of the plans that you have referred to, no question about it, and we are committed to try to make sure those mistakes don't repeat themselves.

For one thing, Blue Cross has been trying to compete over the last several years on an unlevel playing field, and that has been part of the problems that Blue Cross has faced. For example, plans in this area as well as in the Northeast have taken all comers regardless of individuals' health status where other commercial insurers will only take healthy individuals. We think the President's plan will even out that playing field and will help some of those problems.

Second, when you have to compete, we certainly think administrative cost is a place to streamline those procedures and to streamline expenses, and to the extent that people are going to have to compete you can no longer compete on risk selection, competing on managing costs, including managing administrative costs, will help, and I think that will address some of the concerns that have been raised by some Blue Cross plans.

Ms. NORTON. That does sound reasonable.

What do you believe about outside investments and about Blue Cross and other such health care companies running in the mode of large private companies which allow their executives a great deal of latitude in their personal trappings and accoutrements?

Ms. FOX. I would say a couple of things. Blue Cross is really the only health insurer that really, its primary business health. Now that may be true with some HMO's. You will see the commercial insurers; they also have business and other lines—property and casualty, automobile, et cetera. I know there were some issues that some of our other lines of business weren't being reviewed by the State insurance commissioner. We have recommended that change and that all lines of business be reviewed by the State insurance commissioner.

Ms. NORTON. I have a very specific question.

Ms. FOX. Yes.

Ms. NORTON. Do you believe that plans like Blue Cross should have investment outside of the health care field?

Ms. FOX. I think that it is appropriate; yes, I do.

Ms. NORTON. Do you think that in order to do so they should be monitored by the health commissioner?

Ms. FOX. Yes, I think the State insurance commissioner should have access to all the books and all the records.

Ms. NORTON. That is not the case now?

Ms. FOX. That wasn't the case. The Association has said that if you want to be a Blue Cross plan you have to make sure that the State that regulates you has that provision in their books and that you are regulated by the insurance commissioner. Yes; we have recommended that.

Ms. NORTON. So you have no problem with that sort of provision being in President Clinton's plan.

Ms. FOX. We support that 100 percent.

Ms. NORTON. Mr. Bowles, just let me say for the record that I have become familiar with your plan and that it is a courageous plan.

Mr. BOWLES. Thank you.

Ms. NORTON. The very high quality of care, the no holds barred in spending money in order to reach the hardest to reach residents of this city—it is a model that I hope President Clinton's plan takes into account. Without the incentive that may come with that plan, you have really gone into unchartered territory. No wonder you are called Chartered Health Plan, because you are sure chartering it now.

May I ask you, do you regard yourself as competitive with Blue Cross and George Washington University Health Plan?

Mr. BOWLES. I regard Chartered Health Plan as being competitive in the future, and I would like to say thank you very kindly for your comments, Ms. Norton.

Obviously, Chartered Health Plan does not have the financial resources of Blue Cross. Chartered Health Plan, through its network of private, community based physicians, will be competitive from the health care delivery side. Chartered Health Plan is currently in negotiation to strategically enhance its financial capabilities so that it can be competitive.

I would also like to say that through the establishment of a mixed model HMO by the fall of this year we will be quite competitive with Blue Cross serving the underserved population, be it medicaid and/or working poor people.

Ms. NORTON. You have reduced the cost of the District of Columbia in providing health care to low-income residents, have you not?

Mr. BOWLES. Yes, Ma'am.

Let me just say how our premium is paid. When we started the health plan and negotiated with the District back in late 1987, the District brought in an outside actuarial firm to review its costs in the AFDC population that it was spending. After this actuarial determination, the District did make the cost figures available to us and said, "We will let you operate if you will agree to be paid 90 percent of what we are currently spending per capita." So the District, from year one, has really on a yearly basis saved 10 percent per capita for each member we have enrolled.

Ms. NORTON. Ms. Fox and Dr. Ott, have either of you ever considered setting up a facility or plan in southeast Washington or would you consider doing so?

Ms. FOX. I would like to answer that. The D.C. plan contracts with a lot of providers all over the city. For example, D.C. General is part of the select network that has been set up to serve the Federal employees program. There are primary-care physicians that are in the network that are all over the city.

The way the network is selected is to assure that the accounts—for example, the Federal employees people have access to doctors that are located near their home, so that is something that is of very much importance, and that is already there, it is already happening today.

Ms. NORTON. This is through the Blue Cross private providers who are around the city?

Ms. FOX. Yes.

Ms. NORTON. Would you provide the committee with a breakdown of providers by precincts so that we can see where those providers are located?

Ms. FOX. I will try to; yes.

[The information follows:]

QUARTER	SPECIALTY	N
NORTHEAST	ANESTHESIOLOGY	13
	CARDIOLOGY	24
	CLINIC/GROUP PRACTICE	2
	DERMATOLOGY	3
	DIAGNOSTIC RADIOLOGY	2
	EMERGENCY MEDICINE	5
	ENDOCRINOLOGY	1
	FAMILY PRACTICE	13
	GASTROENTEROLOGY	3
	GENERAL PRACTICE	5
	GENERAL SURGERY	22
	INTERNAL MEDICINE	67
	NEPHROLOGY	3
	NEUROLOGY	6
	OB/GYN	17
	OPHTHALMOLOGY	8
	ORAL SURGERY	4
	ORTHOPEDIC SURGERY	6
	OTHER (MISCELLANEOUS)	2
	PATHOLOGY	8
	PEDIATRICS	14
	PHYSICAL MEDICINE	2
	PODIATRY	4
	PSYCHIATRIC SOCIAL WORK	11
	PSYCHIATRY	12

(CONTINUED)

QUARTER	SPECIALTY	N
NORTHEAST	PSYCHOLOGY	5
	PULMONARY DISEASE	2
	RADIOLOGY	20
	SURGICAL CRITICAL CARE	1
	THORACIC SURGERY	2
	UROLOGY	7
	ALL	294
NORTHWEST	SPECIALTY	
	ALLERGY	8
	ANATOMIC PATHOLOGY	5
	ANESTHESIOLOGY	140
	CARDIOLOGY	88
	CHILD NEUROLOGY	1
	CHILD PSYCHIATRY	8
	CHIROPRACTIC	1
	CLINIC/GROUP PRACTICE	5
	CLINICAL PATHOLOGY	2
	DERMATOLOGY	28
	DIAGNOSTIC RADIOLOGY	39
	EMERGENCY MEDICINE	38
	ENDOCRINOLOGY	7
	FAMILY PRACTICE	31
	GASTROENTEROLOGY	20
	GENERAL PRACTICE	8
	GENERAL SURGERY	108

(CONTINUED)

QUARTER	SPECIALTY	N
NORTHWEST	GERIATRICS	3
	GYNECOLOGIC ONCOLOGY	5
	HEMATOLOGY	10
	INFECTIOUS DISEASE	13
	INTERNAL MEDICINE	387
	MANIP. THERAPY	1
	MATERNAL/FETAL MEDICINE	1
	MAXILLOFACIAL SURGERY	1
	NEONATOLOGY	15
	NEPHROLOGY	24
	NEUROLOGY	67
	NEUROSURGERY	27
	NUCLEAR MEDICINE	13
	OB/GYN	187
	OB/GYN CRITICAL CARE	1
	ONCOLOGY	20
	OPHTHALMOLOGY	72
	ORAL SURGERY	27
	ORTHOPEDIC SURGERY	52
	OTHER (MISCELLANEOUS)	18
	OTOLARYNGOLOGY	40
	PATHOLOGY	95
	PED. CRITICAL CARE MED.	1
	PED. HEMATOLOGY/ONCOLOGY	1
	PEDIATRIC CARDIOLOGY	13

(CONTINUED)

QUARTLR	SPECIALTY	N
NORTHWEST	PEDIATRIC SURGERY	2
	PEDIATRICS	170
	PHYSICAL MEDICINE	30
	PLASTIC SURGERY	22
	PODIATRY	55
	PROCTOLOGY	3
	PSYCHIATRIC SOCIAL WORK	181
	PSYCHIATRY	145
	PSYCHOLOGY	117
	PULMONARY DISEASE	17
	RADIATION ONCOLOGY	6
	RADIOLOGY	178
	REPRODUCTIVE ENDOCRINOLOGY	4
	RHEUMATOLOGY	13
	SURGICAL CRITICAL CARE	3
	THERAPEUTIC RADIOLOGY	2
	THORACIC SURGERY	18
	UROLOGY	42
	VASCULAR SURGERY	4
	ALL	2643
SOUTHEAST	SPECIALTY	
	ALLERGY	1
	ANESTHESIOLOGY	13
	CARDIOLOGY	4

(CONTINUED)

QUARTER	SPECIALTY	N
SOUTHEAST	CLINIC/GROUP PRACTICE	2
	DERMATOLOGY	2
	EMERGENCY MEDICINE	1
	ENDOCRINOLOGY	2
	FAMILY PRACTICE	9
	GENERAL PRACTICE	4
	GENERAL SURGERY	4
	INTERNAL MEDICINE	49
	NEPHROLOGY	8
	NEUROLOGY	6
	NEUROSURGERY	1
	OB/GYN	11
	OPHTHALMOLOGY	5
	ORAL SURGERY	8
	OTHER (MISCELLANEOUS)	2
	PEDIATRICS	12
	PHYSICAL MEDICINE	2
	PODIATRY	8
	PSYCHIATRIC SOCIAL WORK	9
	PSYCHIATRY	3
	PSYCHOLOGY	7
	PULMONARY DISEASE	2
	RADIATION ONCOLOGY	2
	RADIOLOGY	13
	THORACIC SURGERY	1

(CONTINUED)

QUARTER	SPECIALTY	N
SOUTHEAST	UROLOGY	2
	ALL	193
SOUTHWEST	SPECIALTY	
	ANESTHESIOLOGY	2
	EMERGENCY MEDICINE	2
	FAMILY PRACTICE	1
	GENERAL SURGERY	3
	INTERNAL MEDICINE	5
	NEUROLOGY	1
	OB/GYN	5
	ORAL SURGERY	2
	ORTHOPEDIC SURGERY	1
	OTHER (MISCELLANEOUS)	1
	PEDIATRICS	2
	PODIATRY	4
	PSYCHIATRIC SOCIAL WORK	1
	RADIOLOGY	5
	ALL	35
UNKNOWN	SPECIALTY	
	ANESTHESIOLOGY	10
	DIAGNOSTIC RADIOLOGY	1
	EMERGENCY MEDICINE	11
	FAMILY PRACTICE	1
	GASTROENTEROLOGY	1
	GENERAL PRACTICE	1

(CONTINUED)

BCBSNCA PARTICIPATING PROFESSIONAL PROVIDERS
LOCATED IN THE DISTRICT OF COLUMBIA

QUARTER	SPECIALTY	N
UNKNOWN	INTERNAL MEDICINE	2
	MAXILLOFACIAL SURGERY	1
	OB/GYN	1
	ORAL SURGERY	1
	OTHER (MISCELLANEOUS)	2
	PEDIATRICS	1
	PSYCHIATRY	1
	PSYCHOLOGY	4
	RADIATION ONCOLOGY	3
	RADIOLOGY	3
	THERAPEUTIC RADIOLOGY	1
	VASCULAR SURGERY	1
	ALL	46
ALL		3211

Ms. NORTON. Dr. Ott.

Dr. OTT. We would be willing to consider the possibility of constructing one facility. We don't have the financial resources to build facilities all over the city.

Most of our development in the future is likely to come through further development of our independent physician network. But we currently serve a significant number of patients from southeast Washington at the present time.

Ms. NORTON. Those people are part of the health plan?

Dr. OTT. Yes.

Ms. NORTON. I am now talking, of course, about low-income people, Dr. Ott. Do you serve any medicaid patients in your health care plan?

Dr. OTT. Our health plan originally started with a medicaid base. That contract was terminated by the Federal Government because we were not a federally qualified health plan at the time, but we have expressed our interest in dealing with the medicaid contract when it becomes available to us in the District, and we are in the process of signing a contract with the State of Maryland to serve medicaid patients in Maryland as well.

Ms. NORTON. Thank you very much.

May I say finally for the record, Dr. Bowles, that I am aware, of course, and my office is working with you on this question of 75/25, whereby, one could understand it in the beginning, there exists a rule that says that a health care plan like yours has to have 25 percent of its patients from private plans. This was used as a proxy for judging quality.

Competing with far larger, more traditional plans—that has been impossible not only for you but for the few other African American plans around the country, and we are making a concerted effort to not use proxies for quality but indicators of quality, and I do want to say for the record that this plan, which is absolutely indispensable to the District of Columbia—if it were to go out of existence today, we would have a health care crisis of the kind that has never been seen before—this plan has, in fact, had substantive quality reviews and time after time has been shown to deliver high quality health care.

I think that in the President's plan we must make sure that plans that have taken the risk, gone where others fear to tread, are judged on a level playing field by what they actually do and not by such proxies which have made it difficult for you to operate, difficult for you to get capital, while serving the people in our city that most need serving.

Thank you, Mr. Chairman.

Mr. MCDERMOTT. Thank you.

Let me ask a couple of questions of Ms. Fox.

You raise the question of your program of sorting out the physicians who are most efficient and getting them into an HMO. I am aware that process has gone on with the Blue Cross program in Washington State. Is that a national program that each Blue Cross plan is now selecting out certain physicians and putting them in one low-cost option or lower cost option?

Ms. FOX. There are 71 Blue Cross plans. They are all independent, and they are all doing different things. The Washington plan—

your Washington plan—is using a system that is similar to the program that is used by the D.C. plan, but other Blue Cross plans are using other variations.

Mr. McDERMOTT. That is sufficient for me to know that. Are you then in support of or would you oppose a provision that said that any willing provider should be able to get into your plan?

Ms. Fox. We would definitely oppose such a provision.

Mr. McDERMOTT. In Washington, DC., what is the percentage of physicians that you include in your plan, and how many do you exclude?

Ms. Fox. I cannot tell you the percentage. I can tell you that in the most restrictive network, the tightest network, which is the HMO, which is Capital Care, there are 3,200 physicians covering the D.C. and metropolitan area, including Maryland and Virginia suburbs. So it is a very hefty—I think it is 40 or 50 percent of the physicians, and we just feel very strongly that we really need to recruit the doctors that are providing high quality care cost-effectively and to target those physicians into our networks, and the D.C. plan has some very powerful data that shows how much more costs you are going to be spending by going to inefficient providers, and if you could redirect your patients to cost-effective but high-quality doctors, you can really not only reap savings but improve care.

Mr. McDERMOTT. So your feeling is that when you put this plan together everyone will come to this plan because they get low cost and they get high quality, correct?

Ms. Fox. Yes.

Mr. McDERMOTT. Now, as the population all shifts to that program, the doctors are not going to have enough time to see everybody. That is reasonable to accept, isn't it?

Ms. Fox. You cannot just look at it in isolation, and we have just begun this, it is really this year, so this is really new. But what we hope to see, what we expect to see, is that by encouraging providers into our network and giving them the volume, that we are also going to be affecting the behavior of providers that are not in our network because they will want to be in our network, and part of this program is to provide feedback to physicians as to why their practice patterns vary and to give that information back to them so they can understand.

Mr. McDERMOTT. So if they say, "Well, I'll take a 10 percent cut in my fees," then you will let them in?

Ms. Fox. No; not if they are——

Mr. McDERMOTT. So they are excluded?

Ms. Fox. They would be excluded from the——

Mr. McDERMOTT. When could they possibly measure up and be included?

Ms. Fox. I'm not sure. I think possibly on an annual basis. I could get back to you on that. I'm not really sure how the D.C. plan operates, but it varies across the country. But the goal is to try to give people opportunities to come into the network definitely and also to drop people from the network if they are not meeting their performance objectives, which, by the way, in a lot of Blue Cross plans does not mean that you are being cost-effective only, I mean that is certainly a key part, but there are objectives that you

are responsible for immunizing 98 percent of your kids by the time they are two or whatever the criteria, that women are getting their mammograms on time, so there is a lot, and there is an attempt to get quality measurements into this performance system.

Mr. McDERMOTT. In your recommendations in your testimony, you talk about community rating with limited demographic adjustments. Those are your words. Can you tell me what those limited adjustments are?

Ms. Fox. We are talking about allowing an adjustment for age and also geography.

Mr. McDERMOTT. Geography being what? You mean they live in Anacostia?

Ms. Fox. No, sir. For example, some people are talking about having a HIPC cover Frederick as well as the D.C. area. If you include Frederick in the District of Columbia, you are going to raise the rates for people that currently live in Frederick, Maryland, because they are getting lower rates because it is based upon the fact that they are in a low-cost community. So you need to be sensitive to the fact that where you draw your boundaries is going to have redistributional effects for cross subsidies and low-cost/high-cost areas. So we think that especially you need to account for those differences.

Mr. McDERMOTT. You would suggest then that the system have a provision that allows the carving out of the high-cost areas, sort of putting them by themselves so that the others can benefit from the low-cost aspects of their area?

Ms. Fox. I think you need to have geographic differences. For example, if you said New York State all had to have the same rate, what you would have is, you would have a lot of upset people in Buffalo sending their money down to New York City.

Mr. McDERMOTT. Isn't that what insurance is all about? Isn't it the sharing of risk?

Ms. Fox. The Federal employees program, for example, is nationally community rates; there is one rate across the country; there is no difference in geography. It certainly can be something that can be considered. The problem is the transition to something like that. You are going to have a lot of upset people the way you structure it, and you need to be cautious on how you proceed on that.

Mr. McDERMOTT. One of the things that is interesting in your testimony is that you suggest not waiting for HIPC's to be in place before the insurance reforms are put in, and I wonder if it would be accurate to say that you really advocate holding off a Federal mandate on HIPC's.

Ms. Fox. Well, we think you need to be careful about how you do it. We think you should get insurance reform right away, don't wait on that one minute, get it enacted as soon as possible, and get those standards in place. HIPC's, there are a lot of unanswered questions, and we are not sure how the Clinton package is going to design them, and we think you need to proceed cautiously there.

Mr. McDERMOTT. So you really would rather have it be voluntary rather than something mandated from the Federal level?

Ms. Fox. We think you need to experiment before you depend 100 percent. For example, if you said in New York City today employers up to 500 are in this HIPC, and you tell all employers to

drop their existing insurer and go down to this HIPC, how big would you need—you know, it is a high risk strategy. We just think you need to be cautious there.

Mr. McDERMOTT. It has been a long time coming on this one.

Mr. Bowles, you have three plans in your HMO. You have something called the Chartered AFDC Program, and Chartered Select, and Chartered Choice. Can you tell me what the differences are from the Choice and Select from what you provide to the medicaid people?

Mr. BOWLES. First of all, the medicaid AFDC program has the most lucrative benefits.

Mr. McDERMOTT. The most?

Mr. BOWLES. The most.

I am a member of Chartered Select—my family and I are members of Chartered Select, which is our high option plan. That is our high option commercial plan. Chartered Choice is a lower option plan of the commercial plans that we have. We also have a newly created plan called Chartered Standard which we were asked to create for the District of Columbia personnel.

The medicaid program has the most benefits.

Mr. McDERMOTT. What is the difference in cost between the medicaid program and Select? Give me a comparable figure for a family of three or four or something like that.

Mr. BOWLES. For a family of three, the medicaid plan pays Chartered $116, composite—not for a family, it is the composite rate for individuals.

Mr. McDERMOTT. So three times $116.

Mr. BOWLES. Exactly.

Mr. McDERMOTT. OK.

Mr. BOWLES. For a family in our Chartered Select high option commercial product, the rate is $453. In Choice, which is a lower option plan——

Mr. McDERMOTT. Four fifty-three combined?

Mr. BOWLES. Four hundred and fifty three dollars and 82 cents combined; yes, sir, for a family.

Mr. McDERMOTT. For a family of three or——

Mr. BOWLES. Whatever the family size is. In medicaid we know a family is approximately three people; in commercial, you have somewhere between four and five in a family.

Mr. McDERMOTT. OK. So you figure on a medicaid family five times $116, and then on a Select family you are figuring the combined total for a family is $456 for three people, on average.

Mr. BOWLES. Four hundred and fifty-three—let's say $454, to round it off. But what I am also saying—for a medicaid client, we are saying that for a family of three the composite of premium revenue is $348. I think that is very important.

Select is a high option plan. It has fully covered primary care and prevention services, fully covered hospitalization, minor copays on primary care office visits and specialist office visits.

The Chartered Choice product was developed for people who traditionally never had insurance, and how that came about is that we worked with associations and unions who were organizing people who did not have benefits, and they wanted some level of benefit because the employers were not going to pay but only so

much. So we designed this program that, one, promoted primary care services; two, stressed prevention; and reduced some of the riders. The riders are pharmacy, vision, and dental.

So we created that product so that people would be able to have basic benefit coverage and add the riders consistent with how the employer and/or the organizing organization wanted it. We have been able to get more people insured by creating that product.

Mr. MCDERMOTT. If I understand correctly, in the District there are about 1,843 primary doctors in the District's medicaid program. According to your written testimony, you testified there are 223 primary care and specialty care physicians. How many of those 223 are actually primary-care physicians?

Mr. BOWLES. Seventy-one, sir. As we speak, according to their testimony 71. I know of approximately seven people that we are contracting with we will probably have additional contracts with this week. But right now we have 71.

Mr. MCDERMOTT. You have listed 58 primary care sites.

Mr. BOWLES. Yes.

Mr. MCDERMOTT. I assume those are physicians' offices.

Mr. BOWLES. These are private physician offices where there are one or more primary care physicians working there. That also includes the site that we established on Capitol Hill on Constitution Avenue, that we established as a company through our subsidiary.

Mr. MCDERMOTT. In your testimony you said through Chartered's health care systems design Chartered's ability has enhanced its commitment to access. What is that system of access? What are you saying by that?

Mr. BOWLES. Let me give you an example. First of all, I would like to back into this and say that Chartered Health Plan currently contracts with seven District of Columbia hospitals, and we have different types of contracts. Four of them are teaching hospitals, and a rehabilitation hospital.

We say we have created more access because what we have done is gone out to facilitate for people who have not been used to going to primary care services or have their personal physician and created a relationship between that particular person and a private physician. Therefore, these physicians, because of their desire to work with us, have taken in additional medicaid persons.

A number of doctors have refused to provide care in the fee-for-service sector, and they have been willing to contract with us because we have been somewhat of an enhancer. Part of that enhancement has been because, one, we facilitate those medicaid people getting to physicians' offices. Second, we do hold weekly health educational classes.

When we first started, I would see maybe one or two people in the prenatal class. Now I am seeing over 25 people in a week in the prenatal class. We have nutrition classes. So this has been an act of empowerment for the previously underserved people. So that is what I mean.

Mr. MCDERMOTT. What is your immunization rate among your kids under the age of 5?

Mr. BOWLES. I would say somewhat in excess of 65 to 70 percent. The reason I say it that way is because one of the things we found out—in the regular system, the private physicians were not get-

ting, for whatever reason, through their coordination—were not getting their vaccines.

In January 1991, I made a decision that the company would buy the vaccines and distribute them to our primary-care physicians free, and what we wanted were reports. So we went somewhere from about, really, literally, approximately 40 percent to, I would say, over 65 to 70 percent now, and I expect it to get better because there are incentives. I mean the doctor does not have to search for the vaccine, we provide it. We ask them to keep records.

Mr. McDERMOTT. But still, in your capitated payment to the plan, you are paid for all the kids to be immunized even though you are only at 65 percent.

Mr. BOWLES. We are paid for immunizations, not—I would challenge the actuarial dollar there because I know what I am spending and it is not included in that dollar; that dollar does not cover what I really have to pay. So, I would challenge that; that is the only thing I am saying.

Mr. McDERMOTT. But at least in the contract it is expected. You might argue about the dollars.

Mr. BOWLES. Sure.

Mr. McDERMOTT. But in the contract you are expected to immunize.

Mr. BOWLES. Sure, and steps we have taken to increase our immunizations have been to hold weekend special sessions to bring people in, because the rate of immunization is not a function of the doctor not wanting to immunize, it is a function of parents bringing their kids to the physician to be immunized. So a great educational process is needed there.

Mr. McDERMOTT. I am not suggesting that the population that you are trying to struggle with are easy problems to solve.

There is another one that I raised earlier with the people, and I want to raise it with you, because in your testimony you say a staff position—that is, to inform, educate, and facilitate noncompliant pregnant women in obtaining prenatal care—you have established such a position. That was done in 1991. What has that person done or is that person, in fact, working on this program?

Mr. BOWLES. That person—those people; we now have two. What that person does is, when we find out through either the primary-care physician, referral to an obstetrician, that one of our members is pregnant, we ask for an OB registration form because we want to track the prenatal care from the obstetrician. So, we have that client registered, and that goes very well. Most of our deliveries now have been coordinated, if you will, and accounted for as a result of the OB registration form.

However, there are people—and before I say this, also, when a member joins, comes on board to Chartered, we send out information about the plan written at a level that they can understand; there is also a standard letter that goes out and advocates the member going in to establish an initial health assessment with their chosen primary-care physician.

But we do find people who become pregnant, go see an obstetrician, and fail to make the second or third appointment. At that time—we have two people now whom we send out in the field to attempt to locate that person and, at the time of locating that indi-

vidual, talk with the individual about the need for continued prenatal care, about scheduling to get them into our prenatal classes, and make an appointment not only with the doctor's office but make an appointment with our transportation subsidiary to make certain that we can do everything we can to get that client to go in to the obstetrician and have regularly scheduled and attended prenatal visits.

Mr. McDERMOTT. What kind of success rate do you have in getting compliance with a monthly or whatever, bimonthly, appointment with the physician during the prenatal period?

Mr. BOWLES. With this care and with our whole system, OB registration, regular appointments, I would say the maternal and child outreach representatives now are bringing our prenatal compliance up to about 90 or 95 percent. So, it has had about a 20-percent positive effect because people know now—they know, first of all—it is very strange—they know now that they have an additional advocate; sometimes it requires an additional advocate to go out and sit with them to talk with them about the need for care, and so there is a bonding and a trust relationship that is occurring, and that is something we like to see.

Mr. McDERMOTT. So, it is really a patient advocate as much as somebody who hounds them.

Mr. BOWLES. Oh, yes.

Mr. McDERMOTT. They do not see them as a policeman but more as somebody trying to get them in.

Mr. BOWLES. Right, sir.

I mentioned—I did not go through the entire testimony, but providing care to medicaid clients really has—one has to be committed to serious empowerment through educational programs. It does not occur on the first time around, it is not going to occur the second time around. We send people back over and over again to try to build the trust so that these people will maintain a relationship with their private physician, so it does take time.

Mr. McDERMOTT. Let me ask you a question. This is a little more speculative. You heard the testimony of the acting commissioner of the District who suggested there are five or six others who may want to engage in managed competition with you. How many of those groups do you think really want to come in and do what you are doing?

Mr. BOWLES. I do not think anybody wants to commit to do what we are doing.

Mr. McDERMOTT. So why are they putting their name up?

Mr. BOWLES. I am not trying to be facetious either, but I really do mean that, and I would be shocked if someone does. People have different methodologies in terms of providing how they manage care. Someone is going to have to be very serious to do what we are doing. I think my good friend Jack Ott here just said that he was thinking about a thousand or more, and I believe that, and I am not inferring——

Mr. McDERMOTT. Of the 70,000——

Mr. BOWLES. Yes; I mean I think he has chosen a number that he wants because he has had an experience before—he has chosen a number. But I do not think there are going to be very many people

who are going to make the level of commitment—I will just say that—because it is a long-term effort.

Mr. McDERMOTT. OK. Thank you.

Dr. Ott, I have some questions I want to ask you. I am a Federal employee, and if I join GW what happens to me when I am back in Seattle and I see a physician or go to the hospital there in my district? How does that get paid for?

Dr. OTT. Assuming this is an emergency, unforeseen event, that is covered just like an insurance company would cover you.

Mr: McDERMOTT. Well, I go home on recess for a month in August. If I need some pills or have a cold or something, how is that considered?

Mr. OTT. We would not expect you to have a routine physical examination or something of that sort there. If you need a prescription refilled, that is handled through a national adjudication of prescriptions. You might have to pay for the prescription and then submit a claim, which you do not normally have to do. If your particular pharmacist is hooked up with the national interchange, then it could be done automatically. If you got appendicitis while you were there, obviously we would pay that just like Blue Cross.

Mr. McDERMOTT. We would probably get into a discussion then around whether or not it was an emergency. Is that fair to say?

Mr. OTT. That would be true with any HMO. It is a possible discussion. I think we are probably more liberal than most HMO's in terms of what we will cover, but it is conceivable you could.

Mr. McDERMOTT. OK. Let me ask one other question, because you raised it and I think it is a little bit peripheral to this whole issue. That is the question of the medicaid rates and the talk about freezes and the talk about having some kind of wage and price controls. How is that going to affect your operation?

Dr. OTT. I do not believe I raised that specific issue.

Mr. McDERMOTT. No; you didn't raise it, I am raising it.

Dr. OTT. I do not personally believe price controls will be effective, certainly not in the long run. They have not worked before, and I do not think they are going to work this time either.

How will it affect us? If you tell me that no health plan can raise their premium more than 5 percent, then I will go back to the hospitals and the providers that we do business with and tell them that you have mandated a 5-percent rate increase and therefore that is all we can pay you.

Realistically, I do not know of any hospital in the District that breaks even on medicaid rates. Probably not half of the hospitals break even on medicare rates. So, if you reduce them artificially even further, it will not in the long run be effective.

Mr. McDERMOTT. You will simply get the cost shifted on to the private?

Dr. OTT. I think that is what will happen.

Mr. McDERMOTT. OK. Right now, what percentage of your operation is funded by the university?

Dr. OTT. None.

Mr. McDERMOTT. So the operation of your HMO is totally within the cost of delivery of the care. I mean you are delivering the service. Does the hospital charge you or does the university charge you for the hospital or how is the hospital cost spread to you?

Dr. OTT. We are a separate corporation wholly owned by the university. We have negotiated rates for services which are quite reasonable which help in keeping our premium down. But we also contribute a major volume to the hospital. For example, we account for 15,000 bed days a year.

Mr. MCDERMOTT. What is that percentage in terms of their——

Dr. OTT. Approximately 12 percent of the total.

Mr. MCDERMOTT. Twelve percent of the total.

Dr. OTT. So, again, a volume purchaser. Therefore, you can negotiate a good rate. The university indirectly supports us because we use the personnel system to recruit new employees and that sort of thing.

Mr. MCDERMOTT. How about the cost of your physicians' salaries? I assume that the physicians at George Washington have some salary from the university and some from a private practice plan. That is a pretty standard operation in most medical operations today. What percent of their salaries are paid for out of their practice plan?

Dr. OTT. That varies a great deal from specialty to specialty. I think it could be as little as 10 percent or it could be double the base salary.

Mr. MCDERMOTT. So, all the fees are not thrown into a pot and divided up as needed through the system. The cardiac surgeons have their own pot, and the ophthalmologists have their pot.

Dr. OTT. Given that I am a pediatrician, it is a given that I am not going to make as much as a thoracic surgeon, and therefore you have to have some way to adjust that.

Mr. MCDERMOTT. OK. I want to thank the panel for your helpful testimony.

We will recess until about 1 o'clock; about 15 minutes or so. Congressman Stark will be back at that time.

[Recess.]

The CHAIRMAN [presiding]. If the reporter is ready and the panelists are here, I would like to welcome a panel of hospital representatives: Howard Jessamy, who is president of the D.C. Hospital Association, who is accompanied by John Green, the executive vice president of Medlantic Healthcare Group which operates Washington Hospital Center; Mr. Henry L. McQueeney, who is the acting hospital administrator of Georgetown University Hospital; David Brown, who is president of the Greater Southeast Community Hospital; and Mark Chastang, who is the executive director of D.C. General. We are shy Mark, who I understand will come along in a while, so if you all do not mind, why don't we lead off.

Again, I am going to return to the timer here, not because you get three points if you get it off within that, but we all have other things to get about, I am sure, and you have been very patient, so we will try and move things along that way.

Howard, do you want to lead off?

STATEMENTS OF HOWARD JESSAMY, PRESIDENT, D.C. HOSPITAL ASSOCIATION; JOHN GREEN, EXECUTIVE VICE PRESIDENT, MEDLANTIC HEALTHCARE GROUP (WASHINGTON HOSPITAL CENTER); HENRY L. McQUEENEY, ACTING HOSPITAL ADMINISTRATOR, GEORGETOWN UNIVERSITY HOSPITAL; DAVID BROWN, PRESIDENT, GREATER SOUTHEAST COMMUNITY HOSPITAL; AND MARK CHASTANG, EXECUTIVE DIRECTOR, D.C. GENERAL HOSPITAL

STATEMENT OF HOWARD T. JESSAMY

Mr. JESSAMY. Yes. Good afternoon, Mr. Chairman.

I am Howard Jessamy, president of the District of Columbia Hospital Association. We represent the 17 hospitals in the District of Columbia. Those 17 hospitals include the two Federal hospitals, Walter Reed and the Veterans' Administration Hospital as well.

The District of Columbia Hospital Association, our members, recognize the need for a bold new approach to developing and financing health care in America regardless of what nomenclature we put on it. It is imperative that any reform proposal include several important principles:

Number one, universal access to basic health care services must be guaranteed to everyone regardless of employment or income status. In the District of Columbia this translates to coverage for over 100,000 additional people.

Number two, a vertically integrated delivery system must be developed so that care can be provided in the most appropriate setting, whether it is primary care, acute care, emergency care when appropriate, home care, long-term care, hospice or other types of service in the District. The hospitals, particularly those with emergency rooms, are the safety net for patients who are unable to access other levels of care.

The third principle is that quality care must be the driving force in the health care system. That is, care must be effectively managed and coordinated to meet the needs of the patient. The health system must be community-based and well planned with a goal of improving the health status of the community.

The fourth principle should be that the reimbursement must be designed to promote cost efficient care. At present, the health care system in the District and across the country is filled with conflicting incentives for hospitals, physicians, and other providers. The payment system must encourage providers to work together to cut costs.

Another principle, and not necessarily the last one, but in regard to areas of laws that must be changed or amended to remove impediments to the efficient use of resources, including medical malpractice liability reform and changes to antitrust laws.

D.C. hospitals discharge some 200,000-plus patients each year with an additional 500,000 seen in hospital emergency rooms. About 14 percent of these patients have no health insurance, which translates into an uncompensated care burden of greater than $200 million.

The CHAIRMAN. How much was that?

Mr. JESSAMY. Two hundred and two million dollars.

The CHAIRMAN. Two hundred million dollars for all the hospitals?

Mr. JESSAMY. For all hospitals in aggregate.

The CHAIRMAN. You are not including the military in that?

Mr. JESSAMY. I am not including the Federal hospitals.

The CHAIRMAN. What are the gross revenues to those hospitals?

Mr. JESSAMY. The gross revenue is about $1.8 billion.

The CHAIRMAN. So about 10 percent.

Mr. JESSAMY. Well, 13 percent on discharges; yes.

The CHAIRMAN. Thirteen?

Mr. JESSAMY. Yes; 13 percent on discharges.

The CHAIRMAN. OK, thank you.

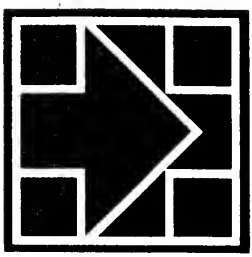
Mr. JESSAMY. What is frustrating about this burden is that although the study that was spoken to earlier by Mr. Shiels, we learned that about 38 percent of hospital admissions of uninsured could have been prevented had the patients received timely primary care. If patients can be guided through appropriate incentives to seek care early in an illness in the most appropriate setting, a $5,000 hospital stay can be traded for a $50 office visit and a $20 prescription. Real savings can be gained by this change in delivery of care. Without it, serious cost reductions will be impossible.

The study we undertook in 1988 brings us important data about the hospitals in the District of Columbia. As Mr. Shiels testified this morning, we need more. However, after 5 years, the additional data—we had some updates this morning relative to the number of uninsured which has grown from 14 percent of the population to 25 percent of the population in the last 5 years, and if 14 percent of our discharges are uninsured, that means that the additional uninsured people are either not seeking care, and some of them probably do need care.

DCHA supports efforts to expand access to data from all providers, not just from hospitals, and from insurers. The availability of data from many sources will greatly enhance the ability of policymakers and providers to formulate health policies that will respond to the needs of the community, and that will make significant improvements in the health status of every individual.

Thank you for the opportunity to participate in the dialogue. We have submitted additional data and charts to staff earlier.

[The prepared statement of Mr. Jessamy follows:]



Testimony before the

COMMITTEE ON THE DISTRICT OF COLUMBIA
House of Representatives
United States Congress

Presented by

Howard T. Jessamy
President
District of Columbia Hospital Association

April 19, 1993

Constance U. Battle, M.D.
Chairman of the Board

Howard T. Jessamy
President

GOOD MORNING. MY NAME IS HOWARD T. JESSAMY. I AM THE PRESIDENT OF THE DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION. WE APPRECIATE THE OPPORTUNITY TO DISCUSS HEALTH CARE REFORM AND ITS POTENTIAL IMPACT ON THE HEALTH CARE DELIVERY SYSTEM, PARTICULARLY RELATIVE TO THE ROLE OF HOSPITALS IN THE DISTRICT OF COLUMBIA.

THE MEMBERS OF THE DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION RECOGNIZE THE NEED FOR A BOLD NEW APPROACH TO DELIVERING AND FINANCING HEALTH CARE IN AMERICA. IT IS IMPERATIVE THAT ANY REFORM PROPOSAL INCLUDE SEVERAL IMPORTANT PRINCIPLES:

- UNIVERSAL ACCESS TO BASIC HEALTH CARE SERVICES MUST BE GUARANTEED TO EVERYONE, REGARDLESS OF EMPLOYMENT OR INCOME STATUS; IN THE DISTRICT, THIS TRANSLATES TO COVERAGE FOR AN ADDITIONAL 100,000 PEOPLE.

- A VERTICALLY INTEGRATED DELIVERY SYSTEM MUST BE DEVELOPED SO THAT CARE CAN BE PROVIDED IN THE MOST APPROPRIATE SETTING, WHETHER IT IS PRIMARY CARE, ACUTE CARE, HOME CARE, LONG TERM CARE, HOSPICE CARE, OR OTHER TYPE OF SERVICE; IN THE DISTRICT, THE HOSPITALS -- PARTICULARLY THOSE WITH EMERGENCY ROOMS -- ARE THE SAFETY NET FOR PATIENTS WHO ARE UNABLE TO ACCESS OTHER LEVELS OF CARE.

- QUALITY CARE MUST BE THE DRIVING FORCE IN THE HEALTH CARE SYSTEM. THAT IS, CARE MUST BE EFFECTIVELY MANAGED AND COORDINATED TO MEET THE NEEDS OF THE PATIENT. THE HEALTH SYSTEM MUST BE COMMUNITY-BASED AND WELL PLANNED WITH THE GOAL OF IMPROVING THE HEALTH STATUS OF THE COMMUNITY. THIS IS NECESSARY IN ORDER TO ACHIEVE QUALITY CARE AT ALL LEVELS.

- REIMBURSEMENT MUST BE DESIGNED TO PROMOTE COST-EFFICIENT CARE. AT PRESENT, THE HEALTH CARE SYSTEM IN THE DISTRICT (AND ACROSS THE COUNTRY) IS FILLED WITH CONFLICTING INCENTIVES FOR HOSPITALS, PHYSICIANS AND OTHER PROVIDERS. THE PAYMENT SYSTEM MUST ENCOURAGE PROVIDERS TO WORK TOGETHER TO CUT COSTS.

- WITH REGARD TO RELATED AREAS, LAWS MUST BE AMENDED TO REMOVE IMPEDIMENTS TO THE EFFICIENT USE OF RESOURCES. THIS SHOULD INCLUDE MEDICAL MALPRACTICE LIABILITY REFORM AND CHANGES TO ANTI-TRUST LAWS.

D.C. HOSPITALS DISCHARGE SOME 200,000 PATIENTS EACH YEAR, WITH AN ADDITIONAL 500,000 SEEN IN HOSPITAL EMERGENCY ROOMS. ABOUT 14 PERCENT OF THESE PATIENTS HAVE NO HEALTH INSURANCE, WHICH TRANSLATES INTO A $201 MILLION BURDEN OF THE COSTS OF CARING FOR THESE INDIVIDUALS.

WHAT IS FRUSTRATING ABOUT THIS BURDEN IS THAT, THROUGH A DCHA-COMMISSIONED STUDY IN 1988, WE LEARNED THAT ABOUT 38 PERCENT OF HOSPITAL ADMISSIONS OF UNINSURED PATIENTS COULD HAVE BEEN PREVENTED HAD THE PATIENTS RECEIVED TIMELY PRIMARY CARE. IF PATIENTS CAN BE GUIDED THROUGH APPROPRIATE INCENTIVES TO SEEK CARE EARLY IN AN ILLNESS IN THE MOST APPROPRIATE SETTING, THE $5000 HOSPITAL STAY CAN BE TRADED FOR A $50 OFFICE VISIT AND A $20 PRESCRIPTION. REAL SAVINGS CAN BE GAINED BY THIS CHANGE IN THE DELIVERY OF CARE; WITHOUT IT, SERIOUS COST REDUCTIONS WILL BE IMPOSSIBLE.

THE STUDY WE UNDERTOOK IN 1988 BROUGHT US IMPORTANT DATA ABOUT THE HOSPITALS IN THE DISTRICT OF COLUMBIA. HOWEVER, THAT WAS FIVE YEARS AGO, AND MORE DATA IS NEEDED IF WE ARE TO DETERMINE HOW BEST TO REFORM THE HEALTH CARE SYSTEM. DCHA SUPPORTS EFFORTS TO

EXPAND ACCESS TO DATA FROM ALL PROVIDERS (NOT JUST HOSPITALS) AND FROM INSURERS. THE AVAILABILITY OF DATA FROM MANY SOURCES WILL GREATLY ENHANCE THE ABILITY OF POLICY-MAKERS AND PROVIDERS TO FORMULATE HEALTH POLICIES THAT WILL RESPOND TO THE NEEDS OF THE COMMUNITY AND THAT WILL MAKE SIGNIFICANT IMPROVEMENTS IN THE HEALTH STATUS OF EVERY INDIVIDUAL.

THANK YOU FOR THIS OPPORTUNITY TO PARTICIPATE IN THE DIALOGUE ON HEALTH CARE REFORM.

The CHAIRMAN. Thank you very much.
Mr. Green.

STATEMENT OF JOHN GREEN

Mr. GREEN. Thank you, Mr. Chairman.

I am here today representing the Washington Hospital Center, which is the flagship institution of the Medlantic Healthcare Group. It is the District's largest hospital as well as the largest hospital in the region.

The CHAIRMAN. How big is it?

Mr. GREEN. Nine hundred and seven beds; 34,000 admissions, employing close to 5,000 individuals. In addition, as parts of our system we also have the National Rehabilitation Hospital, which is a 160-bed national rehab hospital, which serves the region as well, as well as two nursing homes, and ambulatory surgery center in downtown Washington, and also two long-term care facilities.

We have reviewed the various health reform options before the public and before the Congress, and I would like to simply share with you, Mr. Chairman, the most important points for us as a major provider of care.

First is the geographic concern. Right now, approximately 45 percent of the patients admitted to the Washington Hospital Center come from the region as a whole, encompassing both Virginia and Maryland. The same applies to the National Rehabilitation Hospital, which is our rehabilitation hospital.

As a result, as the reform thinkers begin to focus on the issue of health insurance purchasing cooperatives or health plans to provide care, the role that we play at the Washington Hospital Center as a regional tertiary care facility and also a teaching institution training approximately 200 residents a year suggests to us that it is very important that the area that we serve not just be the District of Columbia. We could not support the cost base associated with being a tertiary care center and also a training center on the base of patients from the District alone, particularly when you look at the payer mix for District patients.

The second issue, universal coverage. Again, with 25 percent of the District's residents being uninsured and a significant number underinsured, we believe that an important component of any reform plan must be universal coverage. That will allow us to continue to provide the care that we provide now but will also give us the ability to reinvest in the institution that we own.

The third issue for us will be a question of rates. We take it as a given that there will be an expectation that we be extremely cost effective, but we also believe that it must be important that we be reimbursed at a reasonable rate so that we can provide high-quality care while at the same time be able to reinvest in the institution, and certainly a major tertiary care institution requires ongoing investment.

The final point I would like to make is that for some time we have worked very hard in an attempt to build a health care system. We would hope that health care reform will take into consideration institutions that have tried to build a health care system and that there will be incentives made available so that we have a

desire and a will to see that patients are treated in the most appropriate setting and also that there are incentives for us to link with other providers to provide a broad-based array of services.

Those conclude my comments, and I will certainly respond to any questions that you might have.

The CHAIRMAN. Thank you very much.

Mr. McQueeney.

STATEMENT OF HENRY L. McQUEENEY

Mr. MCQUEENEY. Thank you, Mr. Chairman. I am pleased and honored to present my views on the impact of health care reform on the District of Columbia.

I represent Georgetown University and its medical center. That university has served the citizens of the District and, in fact, of the Nation for over 200 years.

The problems with the current health care system are well known to you and to the country. The matter of the uninsured population cries out for solution. The continued rise in health care expenditures is increasingly alarming and becoming more and more politically unacceptable, and the almost total dedication of health care resources for the acute care setting, particularly toward the end of a person's life, needs to be redirected toward earlier stages of life and into more preventive care.

The task before Congress and, in fact, the country is extraordinarily important and complex. May I suggest three points as you go forward in your deliberations. The economic incentives to restrain costs and to enhance quality of care need to be applied in the same direction for all providers and, in fact, for patients. In my view, this is currently not the case in the existing medicare program.

Second—and this point was spoken to a moment ago by Mr. Green—no health care reform program should restrict or discourage patients from other jurisdictions in receiving their care at District hospitals—that is to say, patients from Virginia or Maryland or elsewhere—and this fear that we have obtains also in other urban areas, multijurisdictional areas.

Finally, Georgetown University Medical Center as well as other teaching hospitals within the District and within the Nation has a primary role of educating students and practitioners in training. Any redesign of the existing health care system should take into account the responsibility which those institutions have in the education of health care providers for future generations.

Thank you, Mr. Chairman.

[The prepared statement of Mr. McQueeney with attachment follows:]

Statement

National Health Insurance Reform and the Implications for Residents of the District of Columbia

Presented by
Henry L. McQueeney, Jr.
Acting Hospital Administrator
Georgetown University Medical Center
Washington, D.C.

to the
U.S. House of Representatives
Committee on the District of Columbia

April 19, 1993

Statement of Henry L. McQueeney, Jr.
to the Committee on the District of Columbia

I am pleased and honored to present my views on the impact of health care reform on the District of Columbia. I represent Georgetown University and its Medical Center. The University has served the citizens of the District and of the Nation for over 200 years. It is in the context of that history that I appear before you.

The problems with the current health care system are well known to you and to the country. The matter of the uninsured population cries out for a solution. The continued rise in health care expenditures is increasingly alarming and becoming more and more politically unacceptable. The almost total dedication of scarce health care resources in the acute care setting, particularly toward the end of the person's life, needs to be redirected toward the earlier stages of life and into more preventive care.

The task before you is extraordinarily important and complex. I would suggest the following 3 points as you go forward in your deliberations:

- The economic incentives to restrain costs and to enhance quality of care need to be applied equally in the same direction for all providers and for patients (this is currently not the case in the existing Medicare Program).

- No health care reform program should restrict or discourage patients from other jurisdictions in receiving their care at District Hospitals.

- Georgetown University, as well as other teaching hospitals within the District and within the Nation, have a primary role of educating students and physicians in training. Any redesign of the health care delivery system should take into account the responsibility which those institutions have in the education of health care providers for future generations.

Thank you very much for the opportunity to appear before you.

GEORGETOWN UNIVERSITY MEDICAL CENTER

Georgetown University Hospital

August 11, 1993

The Honorable Fortney Pete Stark
United States House of Representatives
Chairman, Committee on the District of Columbia
Room 1310 Longworth House Office Building
Washington, DC 20515

Dear Mr. Chairman:

This is a follow-up to my testimony of April 19, 1993 to your committee on the District of Columbia. The issue at hand is the amount of reduction from our current charge structure if there were a single payor system and if there were no bad debt or charity obligations.

Assuming single payor rate, Georgetown would be able to reduce its current charges by approximately 35% given the following assumptions:

- No uncompensated care
- No charity obligation
- No bad debt
- No change in the malpractice situation.

Thank you again for the opportunity for Georgetown University Medical Center to present its views on this very important public policy issue.

Sincerely,

Henry L. McQueeney, Jr.
Senior Associate Administrator

3800 Reservoir Road NW Washington DC 20007-2197

The CHAIRMAN. Thank you.

I am going to ask you later—and it will probably take more time than we have—to tell me what is wrong with medicare, but we will get to that a little later.

Mr. Brown.

STATEMENT OF DAVID BROWN

Mr. BROWN. Good afternoon, and thank you for the opportunity to participate.

I would like to reference my remarks not so much as a hospital administrator but more from the perspective of a hospital that has been involved in many of the aspects that I read about in terms of the future of health care—that is, as a hospital with a large group of contractor physicians which has over 5 years of experience accepting full capitation and taking full risk on behalf of it.

First, a large Washington area——

The CHAIRMAN. Excuse me. Your hospital is the risk taker?

Mr. BROWN. That is correct. Actually, I should say a subsidiary of the holding company of the hospital.

The CHAIRMAN. OK.

Mr. BROWN. More recently, over the past 3 years, in a joint venture with a large mid-Atlantic area health insurer. I think it is that experience that has given us a perspective on the future of health care reform and causes us, frankly, some concern and also has allowed us to experience some opportunities.

By the experience, I say that this health care system, Greater Southeast, has been fully involved in processing claims for payment, developing physician and other provider networks, managing risk pools, and making the payments attendant thereto, developing and negotiating fee schedules, referencing the Blue Cross comments earlier, selecting from its own medical staff a subset of those physicians who are eligible to participate in its very own health care plan, and basically has taken over the last 3 years the risk for about 5,000 lives, and what I would like to report to you is what have we found, how has it been, and what can we learn in terms of where you move in the future.

Frankly, it has been very difficult. Located where we are, literally on the Maryland border, with hospitals that enjoy—and I will speak to later the question you asked relative to the cost review commission of Maryland—but hospitals, frankly, that enjoy very low per diems, which of course are then debited from risk pools which of course give primary care physicians the incentive to use Maryland days, if you will, for what we call the direct, nonemergency types of patients, and perhaps use a larger, more tertiary care hospital like Greater Southeast for patients when they perhaps get in trouble.

We have found it difficult, if you will, in terms of how many lives do you need to actually have an acceptable base to cover your risk. Two months into our experience, one drunken driver hitting a tree costs $100,000 as a result of a helicopter flight to our shock/trauma in Baltimore.

Experience in terms of primary care—and you have already heard in terms of ward 8 what is needed in terms of the future for

primary care is obviously more family practitioners, and we have learned that when you have very few primary care physicians participating in these plans, their plans very quickly become full, very quickly they close them, and therefore the perception among the public is, you no longer have capability and capacity. What you really need, of course, is more physicians.

It is our experience that while you, in fact, may be a primary care physician, the incentives depend upon your training, and the degree of subspecialization may not make you an appropriate player in the managed care market. By that I mean 50- to 55-year-old internists who have practiced fee-for-service medicine all their careers may not be incentivized to all of a sudden accept capitation and begin to refer patients to designated specialists and to understand that the payments for those specialists will be coming out of global fees. We have had much more success with recruiting young physicians out of school where, albeit, the training has been limited in terms of exposure to primary care, at least some of the concepts of utilization review and cost effective medicine may have, in fact, been taught.

We, in fact, as a result of this experience, are looking now to change our risk-bearing relationship with those payers to try to more equitably share the risk in the future until more lives can be brought on line, if you will, into the system.

Our caution would be that you need to make sure that some of the out-of-plan arrangements are taken care of, the playing field is even in terms of Maryland rates and the District's rates, and I would concur with both hospital administrators before me that the idea of regionalization is especially important in this marketplace given three distinctly different markets.

You asked two questions or you asked more than two, but the two I would like to answer for you today are in terms of capacity and the effect of the Maryland Cost Review Commission. Greater Southeast is licensed for 495 beds and basinettes. This morning, we had operating, for a variety of different reasons, 410. Of those 410, 80 percent were occupied. That is, we had a morning census of about 325.

In terms of the impact of the Cost Review Commission, we are fortunate, as Mr. Green is, to be a health care system. That is, we have other facilities besides Greater Southeast, one of which is a small, 33-bed hospital in the affluent Fort Washington suburb of Prince Georges County. You may ask yourself, how can a 33-bed hospital survive in today's environment? Well, this virtually brand new hospital, which has an average daily census of about 65 percent, has an ambulatory surgery load that is booked for the next month, and because of its location, because of the rate structure that has been approved by the Cost Review Commission in Maryland and by its ability to recover its approximately 6 percent uncompensated care load through that structure, we in fact are able to operate a break-even facility which in fact serves as a referral hospital to the larger flagship hospital in Washington.

So our experience has been—and I recount the story only because this week we are going into the public bond market, and we are going to sell $50 million worth of bonds on Wednesday. The number one question asked by both Fitch and Moody's, the rating

agencies out of New York, was: How would your reaction be if Southern Avenue were behind the hospital and you were in Prince Georges County? Our response to both agencies was: We would, as health care administrators, have a much easier time making the system work for the benefit of our physicians and our consumers than it is currently, given the system that we have.

Thank you.

The CHAIRMAN. So you, in effect, are saying you could live comfortably with Maryland rates and the Maryland structure.

Mr. BROWN. Understanding how Maryland rates are established, what we would expect our Maryland rates to be.

The CHAIRMAN. Mr. Green and Mr. McQueeney, have you ever thought about that? How would you guys survive if you suddenly were part—this is not a Statehood issue I am talking about—but if you suddenly had the Maryland system, would you be comfortable with that?

Mr. GREEN. As one who has had some experience with the Maryland system—I was deputy secretary of health for the State of Maryland, and part of my responsibilities was oversight of the planning agency and the rate-setting commission.

The CHAIRMAN. So you have to think it is good, right?

Mr. GREEN. I think that there are certainly some positive things about the Maryland system, but I also think that the Maryland system has not achieved the overall restructuring of the health care system that is necessary. There has been very little competitiveness between the institutions, and the State never has been able to really address the issue of a strong emphasis on primary care, and it has had its own problems in terms of an exploding medicaid budget that has grown from about a billion dollars in 1983 when I was there to $2 billion now, and enrollment has gone up, and, as a matter of fact, if they are not able to constrain the growth in the medicaid budget they may very well be putting in jeopardy the overall rate-setting commission.

So, I think there are some positives about the Maryland——

The CHAIRMAN. I will spot you those, but I must say, I have to admire the fact that they come in with a lower percentage increase in costs. They have Johns Hopkins which, according to U.S. News—I won't make those pronouncements—is one of the better institutions in the country. They operate in some pretty rural areas, and they are doing better than any other price-controlled system as broad. I mean for better or for worse they have a way to allocate capital.

I really do not have any way of knowing how their MRI per capita goes, but I will bet it is more reasonable than Los Angeles County by a long shot. I mean it is theirs; we do not have to run it in a sense, which gives me some comfort.

Mr. MCQUEENEY. I think, Mr. Stark, that our experience is less than John's with Maryland, but our impression is that it does address some of the system issues—for instance, the fair share of charity care and uncompensated care, which I think is adequately, properly addressed.

I think on the negative side, our view is that a system such as that tends to stabilize and create a certain amount of inertia. That might be an unfair characterization.

The CHAIRMAN. If we just suggested to Howard, while we are here why don't we just pass a law and say let's get the Maryland regulations, and we will hit the gavel and vote them in today, and you guys can all operate as—you have the board right here.

Mr. JESSAMY. But that would not be called reform. It would help preserve the franchise, and as a person who has operated a hospital in Maryland in the past, I loved the system when I was operating a hospital there because you could not technically go out of business, regardless of what your costs are, you would just be penalized and it would be taken out of rate.

The CHAIRMAN. But, on average, they still go up in cost less than——

Mr. JESSAMY. Than the national average.

The CHAIRMAN. Right.

Mr. JESSAMY. But so do the costs in the State of Minnesota.

The CHAIRMAN. Yes; but if you come from California, which is an embarrassment—you know, we are running 50 percent occupied, and we are building hospitals chock-a-block. The lower the occupancy, the more these guys come in and build. We probably have more MRI's—seriously—in Los Angeles County than you guys have in this whole corridor, and there is no control there.

Mr. GREEN. I would just say, Mr. Chairman, certainly we would be delighted if we got all the bad debt and charity covered in terms of the way that is done in Maryland, but I am also trying to look at this above and beyond just the needs of the institutions.

The CHAIRMAN. OK, I hear you there, and I recognize that Maryland has now just moved into dealing with the doctors, which may be more their concern, and that may not be as successful as they have been.

Let me ask each of you if you know this. We heard the 13 percent uncompensated, and I presume that is uncompensated and charity.

Mr. JESSAMY. Right. It is bad debt and charity—let me correct that. It was 13 percent in 1990/1991. It is about 11.6 percent.

The CHAIRMAN. Where would each of you three put your hospitals on medicare reimbursement? Are we paying you 90 percent; 80 percent; 95 percent? Mr. McQueeney complained about medicare. I presume it is only that we are not paying you enough.

Mr. MCQUEENEY. No, sir. It is the design of the system.

Let me speak directly to the prospective payment system, the portion of which we are most familiar with. I think it is a well thought out and simple and well founded methodology. The difficulty that I was speaking to was that the medical staff does not operate under the same kinds of incentives that the hospitals do, and my only point was that in future legislation that issue, going in the same direction incentive-wise, ought to be——

The CHAIRMAN. I guess my question to you is, just because in our other committee we think of ourselves as the board of directors of medicare, if we paid you the medicare rate for everybody who came through the door, could you survive?

Mr. MCQUEENEY. No.

The CHAIRMAN. No. If we upped medicaid, no more uncompensated, no more charity, how flat would you be?

Mr. McQUEENEY. Right now, we feel we get reimbursed about 80 percent of our legitimate costs.

The CHAIRMAN. Those costs include uncompensated and charity cases.

Mr. McQUEENEY. That is correct. So I could not give you an answer, but I think that we would be comfortable with the methodology of the prospective payment system and that there would need to be——

The CHAIRMAN. Could you get those numbers?

Mr. McQUEENEY. Yes; we could.

The CHAIRMAN. One of the reasons that I think hospitals do not like it, but one of the joys is, if you were in California I would have those numbers because the California Hospital Association reports to us on all revenue and all costs. I have heard from hospitals for so long how they are going to go broke next year, and this is tough to do in California when you, as some of them, are cutting a fairly fat financial statement with 50 percent occupancy; that is a little tougher to do.

I sometimes think that, on average, if we did pay everybody the medicare—I have been led to believe that we pay pretty close to 90 percent nationwide. Now that has nothing to do with teaching hospitals, which may have some real problems with that. But, in a sense, if we picked up all the uncompensated and, in fact, if you clock in the overhead saving on a single payer system, then I bet you would make it. Well, we will come back to that. But I would really love it if you would think about that some time.

Could you lay off one employee for every two beds if you had no—I mean if you did not have a bookkeeping department basically, you just had a DRG department, and you had one payer, and you got paid the medicare rate, no more medicaid, no more uncompensated, no more charity—how that would clock out? Because those are the only numbers we know. In all these other plans we are picking numbers off some imaginary skyline, and we can't get to a cost thing.

I hate to keep harping back on it, but those are numbers I know, they are certainly numbers all of you know, and that at least would get us to some kind of an idea.

What does that do for you, Mr. Brown?

Mr. BROWN. I do not have the number right off the top of my head. I know that we would agree that if there were capital included, if the rate was reasonable, we would look toward moving toward that kind of a system and could be comfortable. I would be happy to have my staff get that number to your committee.

The CHAIRMAN. OK.

[The information follows:]

Greater Southeast Community Hospital
1310 Southern Avenue Southeast
Washington, D.C. 20032
(202) 574-6000

David E. Brown
President

August 12, 1993

TO : Doneg McDonough
Legislative Assistant

FROM : David E. Brown

SUBJECT: District of Columbia Committee Hearing

Pursuant to your request and our recent communication, Greater Southeast Community Hospital would "need" a rate of approximately $6400/discharge if all patients were insured and there was a single payor system.

Please call me at 574-6812 if you have any questions.

DEB:brt

The CHAIRMAN. I wanted to come to Greater Southeast for a minute on your capitated system. You have just one system?

Mr. BROWN. We have an IPA that has a joint venture with the hospital corps.

The CHAIRMAN. Where do you put the primary care doctor at risk in that? Is there a dollar amount or can you explain that to me just briefly?

Mr. BROWN. Sure. Basically, he gets a global capitation per member per month. If you subtract laboratory on a composite basis, that would be $13.50. From that, he is to provide all immunizations and other hospital, office-based, and ambulatory care.

We also then put aside, if you will, as I know you have experience in California, doing a percentage of that, which we call withhold. From that withhold and from what we define to be a specialty pool, we are responsible for all specialty claims, emergency visits, in plan, out of plan, in area, out of area, and then we are the insurer. Because of a ruling by the commissioner of insurance in Maryland, the insurance company holds for the hospital a separate hospital pool from which also the primary care physician is at risk in that as claims for hospitalization are paid out of that pool.

The CHAIRMAN. So, if I am a primary-care doctor, I am not at risk of getting hit for $20,000 or $30,000 out of pocket if I get a clinker.

Mr. BROWN. No. You are at risk for not having your withhold returned.

The CHAIRMAN. My withhold is the risk.

Mr. BROWN. Exactly. Also you are at risk for not getting any kind of a bonus if the plan would be successful.

The CHAIRMAN. So, I am comfortable with that. But you do have to go outside then. You have to insure, you cannot self-insure.

Mr. BROWN. Basically, we have reinsurance per subscriber per year over a certain amount.

The CHAIRMAN. Do you feel that is because of the financial risk or is that because of Maryland's laws? Would you go naked on that if you could?

Mr. BROWN. No. In fact, we have a separate plan where all of our hospital employees are in a fully managed at-risk pool, which we buy out of California, reinsurance, ourselves in the amount of $75,000 per member per year.

The CHAIRMAN. You operate principally in the area of wards 7 and 8, where we have the large population that we think is medicaid potential.

Mr. BROWN. Correct. We have the same experience as Mr. Green; 50 percent of our patients come from Prince Georges County; 50 percent come from wards, mostly 8 and also 7.

The CHAIRMAN. How many could you take into your program, assuming that you would gear up? I guess I would ask both of you this. We are looking at, in the discussion this morning, 55,000. I think that you cannot, in my book at least, and I have no authority on this, but I do not know that you can only take AFDC and leave the SSI folks out there to fill up the emergency rooms. That somehow sounds to me like cherry picking in a financial sense—take the lowest cost folks first. But even that, picking up 55,000, say

40,000 of which are going to be in your neighborhood, could you each take 20,000 over the next year or so?

Mr. GREEN. Are you talking about the Washington Hospital Center?

The CHAIRMAN. Yes. Or could you take 20,000 and could Mr. Brown take 20,000?

Mr. GREEN. I am not sure that we quite have yet a mechanism in place that would allow us to provide a managed care arrangement for the population. I think we may get there over the next year or year and a half because we are beginning to talk with our physicians about a relationship between the private attending medical staff and the institution. If that should occur, I think we might be in a position to assume some of that.

The CHAIRMAN. But you would get into the deal mostly contracting with your doctors, who might very well end up being under one of these other plans. They might be an IPA doctor.

Mr. GREEN. As a matter of fact, Mr. Chairman, Dr. Bowles who was here with Chartered Health Plan—we have a major contract with them. There are some physicians who are aligned with us who are in Chartered Health Plan. So, in effect, that would probably early on, based on the time line Mr. Coronado laid out of August in terms of trying to begin—or later this year, pull it together, the major role for us would be as a contractor.

The CHAIRMAN. But in your case, you are an integrated plan in a sense, so you would be bidding directly. You kind of got a hint of what they are talking about offering. Maybe you are in those negotiations now. How many people could you take, would you guess? What is a bite size for your capital structure?

Mr. BROWN. We have talked with one of the HMO's that he listed about the possibility of taking 5,000 initially, with our own board of directors, of this PHO I call it, talked with our own doctors about doing it ourselves. Frankly, the liability for us is that we have no experience in enrolling not only that population but any other population. That is one of the reasons we joint venture with insurance companies; that is expertise they have that we do not. Frankly, we are talking with some of the other insurance companies as well as to whether or not we rent them our network, if you will.

I have to be careful how I answer some of these questions. I know there are people in the room we are negotiating with.

The CHAIRMAN. What could Georgetown do, Mr. McQueeney? I do not know if you have any outreach clinics that would serve those particular neighborhoods. But considering the transportation question and assuming that we are not going to give Georgetown a freebie because you can sign up a lot of people but they would not be able to come, so they will have to go to Mr. Green's emergency room. Let's assume that does not happen. What could Georgetown bite off of this population?

Mr. MCQUEENEY. Georgetown sponsors a family medicine practice program, residency program. It is largely associated with Providence Hospital, but it is under Georgetown University auspices.

I would say that, at the risk of being overruled by my superiors, our capacity could be on the same order that Mr. Brown said.

The CHAIRMAN. Mark has arrived. I will let him chime in.

Howard, can the District pick up these 55,000 people in a year?

Mr. JESSAMY. Well, the people are already in the system in some format. They are accessing the system at the wrong point.

The CHAIRMAN. Yes; but it is so different that I am just saying——

Mr. JESSAMY. There is enough capacity in the District. As a matter of fact, if the District was successful in enrolling everyone in a managed care program, you would need less hospital capacity than what you have today in the District.

The CHAIRMAN. One assumes that.

Mr. JESSAMY. One assumes that, and I would almost say that what we would really be looking at is not so much in terms of bed count, but consolidation of services across the District.

The CHAIRMAN. But let me tell you what my experience is, and it is not certainly directed at any of the people we have talked with today, but there are people like this in the world, and the best example would be this guy in Florida who had an IMC and had, you know, I do not know how many thousand seniors down there, and the guy just left town with about $30 million worth of the hospitals' and the doctors' money. We had a clown like this in Los Angeles—Paracelsus or Clesis; I can never remember which Greek it was. At any rate, they stole money.

The point is that there is a temptation sometimes to enroll people with a great deal of enthusiasm and promise and/or selection. I mean it does not take much to imagine that I would figure it was much easier in this new Stark-McDermott plan. There is no sense my trying to bargain with you guys. You know what you are doing, and you are not going to give me a low rate. My chance is to go out into the neighborhood and figure out that I can figure out which ones of those folks, without breaking any of Mr. Coronado's laws, are going to be very costly to me. I am just going to have a lot of, "Oops, sorry, Ma'am; I did not mean to come to this house," because the person happens to be pregnant or would indicate to me, for some other reason, they are going to be high cost.

I mean risk aversion is the cheapest way for an insurance company to make money from the get-go. You guys can only go down so low, and there is no incentive that I can think of for you to bargain way below your costs for very long even for a loss leader. Maybe there is; you could tell me about it.

I would like to just welcome Mark Chastang, the executive director of D.C. General.

Would you like to enlighten us about D.C. General and how it is going to fit into this plan for a minute?

STATEMENT OF MARK CHASTANG

Mr. CHASTANG. Yes, sir.

First of all, let me apologize for having to run out.

The CHAIRMAN. That is quite all right.

Mr. CHASTANG. They are having a survey at the hospital, and I wanted to make sure the surveyors knew I considered their presence very important.

D.C. General is the only public hospital here in the city of Washington, and we are a very busy and complex organization. We have

major teaching affiliations with Georgetown and Howard University schools of medicine.

Just a few facts about the hospital. We are one of the largest providers of out-patient services. We performed approximately 110,000 out-patient visits last year. We have the busiest emergency room and trauma unit in the city of Washington. Combined activity in those two services at D.C. General was approximately 83,000 visits last year. We had approximately 14,800 admissions.

D.C. General is the city's hospital. Our mission is to provide health services to anyone and everyone, regardless of their ability to pay, and in a city where one out of every four individuals is uninsured, where 2 percent of the population is incarcerated, where AIDS is increasing at an alarming rate and so is drug-resistant tuberculosis, we have a very formidable responsibility and we meet that responsibility gladly.

D.C. General is very much alive and well. We are a major player in the medicaid business here in the city of Washington, and we very much intend to participate in the medicaid managed care program as it unfolds in the coming months. We will solve the problem at the table here, Mr. Chairman; we will take all the medicaid patients and do quite well with them.

We have been providing in our children's center, for example—second to Children's Hospital, we are the largest provider of pediatric services. As you may know, our major service areas are wards 5, 6, 7, and 8. In our out-patient services, for example, pediatric services, we provided some 25,000 out-patient visits last year.

We have taken a leading role here in the city in the area of immunizations. We, for the last several years, have launched a major initiative to make sure that all children in the District, regardless of their ability to pay, have immunizations. We have taken a particular interest in the Latino community. Just this past year, we immunized some 800 children in that community. We sent transportation out to pick them up. We established relationships with the Clinic de Pueblo and have done many things in this area.

So we bring to this discussion a wealth of experience, and we are delighted to be a part of the planning and analysis as we go forward with health care reform.

Thank you.

[The prepared statement of Mr. Chastang follows:]

Government of the District of Columbia
District of Columbia General Hospital
19th Street and Massachusetts Avenue, S.E.
Washington, D.C. 20003
Telephone (202) 675-5000

Testimony before the

COMMITTEE ON THE DISTRICT OF COLUMBIA
House of Representatives
United States Congress

Presented by

Mark J. Chastang
Executive Director
D.C. General Hospital

April 19, 1993

Good morning, my name is Mark J. Chastang, I am the Executive Director of DC General Hospital. DC General is the only public acute-care hospital in the Nation's Capitol. Our mission, like so many other public hospitals across this nation, is to provide quality health care services to all persons who present for services regardless of their ability to pay. In a city where one out of every four individuals is uninsured, where 12,000 citizens or 2% of the population is incarcerated, where thousands are homeless daily, where AIDS is increasing at an increasing rate, where drug resistant tuberculosis is threatening more citizens every day, and violence continues unabated, the role of a public hospital is formidable. We are truly a vital institution in ensuring an acceptable quality-of-life for many thousands of citizens in the City of Washington.

I would like to thank you for providing DC General Hospital an opportunity to be a part of these hearings. DC General like approximately 125 similar institutions throughout this country constitute what we often refer to as the "safety net hospitals". Taken together, these institutions

comprise one of America's most important health and hospital systems. Public hospitals provide a substantial amount of the services to Medicaid and low income, uninsured and underinsured patients. In other words, hospitals like DC General serve as "national health insurance" by default in most of our nation's urban areas. The fact that there is time to debate various reform strategies, is a tribute to the fine job that "safety net" hospitals have done historically and are doing today.

As you proceed with the analysis and planning for healthcare reform, I ask that you take a page from the public hospital experience as it relates to cost containment and other aspects of a comprehensive health care reform program. I would like to urge your support, in both the short and long term, for programs to guarantee the continued viability of safety net hospitals such as DC General so that our nation's urban citizens will have access to needed health services whether or not they are ultimately covered under any national health plan.

Please consider the following as you go forward:

- Universal and mandatory coverage for all citizens is vital. Voluntary coverage simply will not assure that many of the uninsured will seek and receive important health services. Without mandatory coverage many of the problems of current programs will simply be perpetuated.

- The eligibility process must be kept as simple as possible. There are millions of individuals who cannot read, write, or communicate effectively. Others are sick, injured, addicted or mentally ill, homeless and often unable to provide basic information about themselves. Presumptive eligibility must be considered.

- Simply issuing a card to patients will not ensure that the patient's needs will be addressed. Various outreach and educational strategies are important to prevent patients, especially children and infants, from becoming victims of preventable diseases.

- Benefit packages should place greater emphasis on primary and preventive care. Incentives must be created to support and encourage preventive services and primary care.

- While managed competition may be an effective strategy under consideration for controlling costs, safe-guards against abuses by insurers must be developed to prevent adverse selection, targeted marketing, "cream skimming" that may result in the sickest and poorest individuals being left to public institutions. Possible safe-guards could include mandatory open enrollment, limitations on advertising and mandatory random assignment of high-risk patients.

Implementation of National Health Reform will require time to phase in. The immediate future of and need for safety net institutions is certain. I ask your consideration for making sure that attention is devoted to a number of short term needs that must be met over the next several years in support of the nation's safety net hospitals.

- a new national capital financing initiative is needed to rebuild and equip America's institutional health safety net hospitals. We applaud the initiatives you undertook, Mr. Stark, as well as Senators Daschle, John Breau and others. I hope that your enthusiasm for this much needed initiative has not diminished and you will soon reintroduce the legislation.

- in the short term, the Medicare disproportionate share hospital adjustment must be preserved and increased.

- continued efforts must be made to improve and reform the medicaid program.

Thank you for the opportunity to make brief comments.

The CHAIRMAN. Thank you.

Let me just try one more question here. I am just trying to get focused. I think we heard this morning that they spend $1.5 billion costs here, and if a quarter of the people are uninsured, that is $400 million. Think about this for a minute. If you assume there are 242,000 uninsured and medicaid in the District, we think we could provide actually for around $1,000 medicare for an under 65 adult; that is our cost, less $400 for a kid, $1,000 for an adult under 65. So let's say they are all adults, which is pretty generous. You are talking $240 million a year.

Then let's say—I do not know what Prudential charges, but you could buy with that kind of a population a fairly good supplemental for $50 a month, pick up the copays, I think. I cannot believe—Prudential's deal with the AARP as much as $70 a month now, so we ought to be able to do it for $50. So that is $150. That gets us down to $400 million for everybody who comes in to see you, has medicare, and that $1,000, by the way, provided first dollar prenatal and first dollar pediatric and a prescription benefit. That would not be such a bad deal for the District, would it? Everybody has medicare. If you want to run an HMO, we will give you a risk contract. You would all get the medicare rate for everybody who came through the door at a minimum; you would still have your private pay outside. How would that work?

Mr. CHASTANG. It is an interesting scenario. I did not completely follow your numbers there, sir.

The CHAIRMAN. We think that the actuarial cost of providing medicare benefits, enriched as I suggested by first dollar prenatal and first dollar pediatric care, and actually a $2,500 out-of-pocket limit, which I did not even include in this, would be about $1,000 for an under-65 adult. It is about $3,000 now for medicare. Kids would be about $450, but those figures are a year or so old, so I am just taking $1,000 a year for every one of your medicaid and medicare. That is $242 million a year. Then I cranked in something for the copays and the deductibles and just picked a figure of $450 million. I do not know the copays and the deductibles would be that high.

That means that, in a sense, everybody walking around in the District of Columbia either has the enhanced medicare ability including the copays and the deductibles, so you are not on the hook for those, and you do not have any uncompensated care. You know what the medicare rates are now; the doctors know what they are. This would be A and B. I imagine it would be a whole heck of a lot less than the District is going to end up paying when they get done shuffling around all this stuff.

We would have to put everybody in, I suspect, so we have no adverse selection, and I am not sure that I can hold those numbers. Those were country-wide numbers that the actuaries did for us. They may have a good bit of windage. But it stands to reason if you figure how much of your care goes to the over-65 population, with these same benefits going to the under 65, that those numbers are not too far off. Why couldn't we do something like that here?

Mr. MCQUEENEY. One of the advantages of such an arrangement would be, it would at least be predictable. I think one of the fears

and one of the reasons why I wake up at night is the fear of the unknown, and that is at least a predictable system.

The CHAIRMAN. You know the system, don't you, Mr. McQueeney?

Mr. MCQUEENEY. Yes.

The CHAIRMAN. You figure it out. You have experts in your hospital who know all the code numbers and what to do.

Mark, you do. I mean you get a good medicare population, I do not know how big, and it sure as heck would be a better rate than you are getting out of medicaid. At least it is the devil we all know. I know the system and its warts, and you know it, and you know where we pay too little and too much. It is an American system, and there are some people who know how to game it, and we have some inspectors general who know how to find that occasional person and arrest them or hassle them.

I am going to quit now and let Dr. McDermott get back to this company we are going to organize. But if some of you would think about that later, how you would come out on that. You do not do any risk contracting now?

Mr. BROWN. In Greater Southeast? Yes; we still do.

I was going to say, the number that we look at which makes a deal plausible is $1,200.

The CHAIRMAN. That is your risk contract rate for——

Mr. BROWN. That is one that we are willing to look at and say perhaps we shall do that, so you are very close.

The CHAIRMAN. Is that for medicare patients now?

Mr. BROWN. No. That is for a commercial contract.

The CHAIRMAN. OK; so, I am not far off, am I? We do not have any profit or overhead, so I can't be that far away.

Do you have risk contracts now for medicare?

Mr. BROWN. No; we have not yet done a medicare risk contract.

The CHAIRMAN. Do you know what the rate would be in the District if we were paying a risk contract here to an HMO? Does anybody know? I do not know.

Mr. BROWN. Prince Georges County used to be among the highest rates in the country at about $450 per member per month.

The CHAIRMAN. Yes; we are in the $300 and something in California. So, you would pick that up if you were an HMO or wanted to be and you would federally qualify.

It has kind of been the germ of an idea that I have had. I do not know, and what we are trying to add up is, if what we subsidize the District's medicaid—they cannot be spending a lot on long-term care because you do not have that many long-term care beds under the medicaid program. I think there might be enough money there to do it. Now how that would all fit—Jim.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I only wanted to go back to a question I raised earlier in the morning, and perhaps some of you were here when I asked it. That is the whole question of violence and the cost of it to the system. Somebody suggested earlier that there was a study done, and if somebody could talk a little bit about that I would appreciate it.

Mr. JESSAMY. Yes, Dr. McDermott. I could outline some of those findings for you. We looked at the cost of criminal violence in the District of Columbia, and we looked at it during the winter of 1989,

so this is December 1989, January 1990, because that was at that time, looking backward, the most violent time in the District of Columbia.

In a summary of those findings—first the bottom line issue: about $20 million a year in uncompensated care or 10 percent of the District's total uncompensated care hospital burden, is attributed to the criminal violence. Hospital expenses per case for violent crimes ranged from less than $1,000 to more than $250,000.

Fifty-five percent of these costs are due to crimes involving firearms; 68 percent of the victims of violent crimes in the District were uninsured. Those uninsured victims of crimes accounted for 10 percent of the uncompensated care in the hospitals in 1989–90.

The cost of care provided to uninsured crime victims is partially paid for from the subsidy to D.C. General Hospital or by cost shifting to those insured patients who use District hospitals. That cost shift for the violence component ranged from a low of $25 to a high of $380 in one of the hospitals. That is the component that you have to add to everybody's bill to make up for the loss.

On a national basis, total health care costs due to criminal violence are estimated to be more than $3.5 billion in 1989, and again we were interested in the firearm component. In the District, over 50 percent of the cost was attributed to firearms.

Mr. GREEN. Dr. McDermott, at the Washington Hospital Center we have the Medstar Trauma Center there, and the trauma center represents a significant portion of the loss that we have sustained there. It represents just the trauma unit alone, about $10 million in terms of uncompensated care.

Mr. MCDERMOTT. What percent of your uncompensated care is that?

Mr. GREEN. Probably about 30 percent.

Mr. MCDERMOTT. Let me ask a question. One of my colleagues on the Ways and Means Committee where Congressman Stark and I both serve represents a major city in the Midwest in which there is no emergency room open in his district, in a major city. Anybody who has an emergency of this sort has to be shipped out of his district.

What is the situation here in the District of Columbia? What percent of the violent crime wind up at D.C. General and what percent is taken by others? Is it a triage, sort of if they are going to stay alive long enough to make the D.C. hospital they are shipped or is it that they are taken in and treated there? What is the situation here in Washington, DC.?

Mr. CHASTANG. We do 60 percent of the trauma here in the city of Washington. Let's talk about gunshot wounds; let's separate that as a category. There were 980 shootings in the District in fiscal year 1992, which was from October 1 to September 30; we did 76 percent of those cases at D.C. General.

One of the reasons that we do so much of it is our location geographically to the scene of the shootings. We are in the southeast quadrant of the city, and the emergency medical services take the patients from the scene of the accident to the nearest open and available trauma unit. So, by proximity, we are predisposed to doing a disproportionately high share of it, and that is one of the primary reasons.

Does that get at the essence of our question?

Mr. McDermott. Yes.

Are there other units in the city that actually—obviously, they are doing 25 percent. Is there any concentration at any other particular facility in the city?

Mr. Chastang. Yes. Of course, Howard does a significant percent and Medstar and GW, Georgetown, and of course Children's for children-related trauma.

Mr. McDermott. Thank you all. Thank you, Mr. Chairman.

The Chairman. One other question, Mark, before I let everybody go. There has been some discussion on closing your facility or converting it to nursing home beds. What would that do to the ability to provide these 55,000 additional AFDC's? I have bids here for about 15,000, I figure, if I can get Mr. Brown and Mr. Green and Mr. McQueeney to stand up at the table for five apiece. I am light for 40,000. Now there are a few hospitals not represented. But if we take you out of that loop, how many medicaid AFDC patients do you treat now, do you suppose?

Mr. Chastang. We have a significant population of AFDC patients. But let me talk about the broader question and then come back to that point. This whole brouhaha about closing D.C. General came about, I think, as a quote/unquote innocent question by the Chair of the council in the District, and it was not couched in terms of closing D.C. General as a specific thought-through strategic action. It was in the context of a budget hearing where the Chair asked what would happen if—just a hypothetical question posed to cabinet members when the Mayor's budget officers were presenting the budget to the council, and from there it just grew and snowballed into a major news event.

The Chairman. Sort of like that insurance company that Dr. McDermott and I are going to start.

Mr. Chastang. Yes. It would be short-sighted and ill-advised in every respect, trauma just being one of the primary reasons.

But if you consider that 57 percent of our patients are uninsured, thrusting literally tens of thousands of uninsured patients on the private network of hospitals here in the city of Washington at a time when many of the hospitals, first of all, are doing a significant amount of uncompensated care already, would throw them into financial ruin, some of them.

Add to that we are a major teaching center for both Georgetown and Howard University Schools of Medicine, and there is a real value to a teaching resource like D.C. General, and while we haven't quantified it, it certainly—let me give you a statistic. In the area of cardiology, for example, every chief of cardiology, as I understand, here in the city of Washington at some point has matriculated through D.C. General's training programs, and many of the other physicians here in the city of Washington have benefited, have honed their skills through training at D.C. General, and in a real sense D.C. General therefore touches the entire community, enhances the quality of medical care for the entire community, not just for the patients who are present at our doors.

Back to the issue of medicaid. We are a major medicaid provider here in the city of Washington.

The Chairman. How many licensed beds do you have?

Mr. CHASTANG. Four hundred and ten adult beds, 72 basinettes.

The CHAIRMAN. That is operating—licensed?

Mr. CHASTANG. That is licensed.

The CHAIRMAN. Your occupancy runs?

Mr. CHASTANG. Around 78 percent.

The CHAIRMAN. OK. I have a list here of everybody, and you are the only one I do not have the numbers filled in for. Thank you.

Mr. CHASTANG. Yes. It is in the information that was presented from DCHA.

The CHAIRMAN. OK.

Mr. CHASTANG. But we are a major cog in the network, the health delivery system network here in the city of Washington.

In order for the system to be healthy, given the demographics, given the geographic, strategic location that we enjoy, given the uncompensated care issue, the uninsured, the incarcerated persons here in the District, the large numbers, the tuberculosis issues, the AIDS-related issues, and other chronic-disease-related issues, and just the enormity of the challenge of serving a community that is unique in many ways, you must have a strong public hospital in order that the private hospitals remain reasonably healthy fiscally and otherwise.

For anyone to think seriously about doing away with D.C. General is for them not to have at least the following facts. If you were to purchase the services that D.C. General provided last year to this community, the 15,000 in-patients, the 110,000 out-patient visits, the 83,000 emergency room visits, it would cost an average of $20 million to $25 million more than the total investment that the city has made through appropriation to D.C. General Hospital.

The bottom line of what I am saying is that it would be fiscally imprudent and simply unreasonable to do away with D.C. General. The city gets an excellent financial deal from having this important institution open.

The CHAIRMAN. Thank you.

Mr. McDermott.

Mr. MCDERMOTT. You raised some other questions which I was thinking about before. How about in this city? What is the number of patients that, if you had other arrangements for AIDS patients, you could discharge? How many AIDS patients do you have sitting in the hospital whom you could put out in some lesser restrictive setting if you had such a setting available?

Mr. JESSAMY. We look at patients not just by that category, except for boarder babies we have in a separate category, but all patients in hospitals awaiting placement, whether it is nursing home or community residential facility or a home with home care, I think is down to around 150 patients in the District hospitals awaiting placement.

Mr. MCDERMOTT. That is at an average cost of somewhere around $500 a day in the hospital?

Mr. JESSAMY. That is at an average cost of something like that, maybe a little bit better than that in terms of the up side.

Mr. MCDERMOTT. You mean a little bit more?

Mr. JESSAMY. More; right.

Mr. MCDERMOTT. So it is 150.

Mr. JESSAMY. Right. I think that was at the end of November.

Mr. McDERMOTT. So, that is about $750,000 per day.

Mr. JESSAMY. Right. But that number used to be 400 in 1987.

Mr. McDERMOTT. What have you done? How did you get that down? Is that more availability?

Mr. JESSAMY. That is more availability of beds that have come on line since that time, and there are also more home-care services available now than in the past as well, and then at least for the HIV community other alternative housing units have come on line as well.

Mr. McDERMOTT. OK.

My other question is this. We earlier heard testimony from the Chartered proposal here in the city, and I wonder how does he contract with you people. What is the process? I mean just actually how is it done? You all submit sealed bids for how many patients you will take or you sit down in a group and argue or what?

Mr. GREEN. In our institutions he comes to us, the Washington Hospital Center, if he wants a relationship with the institution, he wants patients admitted there. Several of the physicians who are a part of his IPA model have privileges at the hospital center. Some of them are actually located in the physician's office building there. So he comes, and we negotiate a rate.

Mr. McDERMOTT. He says, "I'll guarantee you 50 or 1,000 patient days a year, and you ought to give me a rate 5 percent less than what you are charging Blue Cross"?

Mr. GREEN. He has not provided a guarantee yet on patient days, but we negotiate a rate.

Mr. McDERMOTT. So, it is a negotiated rate without a guarantee.

Anybody else?

Mr. McQUEENEY. His approach would be the same as other managed care contracts. You need to know what the volume of service is going to be. You need to know some demographics about the patient population, and you need to discuss the methodology of payment, whether it is a per diem rate or a per admission rate, and then you go back and forth like that.

Mr. McDERMOTT. Have any of you turned down a bid or turned down—you have?

Mr. McQUEENEY. Yes, sir.

Mr. McDERMOTT. You have said it was not enough?

Mr. McQUEENEY. If it is economically disastrous, you do not want to discount yourself so much that you turn yourself into a losing proposition. So there are times when you turn away negotiated business.

Mr. GREEN. We have too. We haven't with Chartered.

Mr. McDERMOTT. You have not with Chartered, but you have with other HMO's.

How about D.C. General?

Mr. CHASTANG. We have talked for some time but haven't come to terms. It simply hadn't made sense financially.

Mr. McDERMOTT. Because you are carrying such an uncompensated load so far, you haven't any room to be giving anybody a discount.

Mr. CHASTANG. You can get a better deal; yes. In totality you can get a better deal otherwise.

Mr. McDERMOTT. Thank you.

Mr. JESSAMY. Dr. McDermott, may I add something?

Mr. MCDERMOTT. Yes.

Mr. JESSAMY. I think that most people are proponents of a managed care type system where there is actually true case management of the patient and not just managing the financial side of it. But one concern that we have in the development of the medicaid managed care program is one that has to do with the appropriate utilization of health care facilities by the patient.

In a traditional system, if an HMO patient utilized services outside of the network there is a financial penalty that the patient bears. In a medicaid population, there is not that financial penalty for someone who continues to use the emergency room, and you have to provide the services for them even though the gate keeper says they do not need to be there.

So, as we get more and more experience with medicaid HMO population and numbers, we need to take into consideration the educational process, the learning, navigating the system. There are up front costs to that, because you cannot pass that type of financial disincentive on to the individual. So, that needs to be factored into both cost and the educational needs of the new beneficiaries.

Mr. MCDERMOTT. In the HMO I worked in Seattle we obviously confronted this problem. What we had were walk-in clinics that really operated from very early in the morning, 5 o'clock in the morning, all the way around to 1 o'clock at night. So that people who worked or whatever had ways to get into a walk-in clinic. How many of you have established that kind of a system in your facilities?

Mr. CHASTANG. We have.

Mr. MCDERMOTT. You have.

Has anybody else?

Mr. BROWN. We are in the final process of architectural renderings. We are going to be developing a fast-track program, if you will.

Mr. MCDERMOTT. So that you can get people out of the emergency room stream.

Thank you, Mr. Chairman.

The CHAIRMAN. I want to thank the panel very much. If you want to stick around, our next panel with the medical societies and you guys, we can just sit around and rewrite the plan this afternoon. We will just lock the doors, and nobody goes home until we get it done.

But I do appreciate your candor and your assistance. We will hopefully be talking to you again, some of us, in our other roles, but as we see how these programs that are going to be coming forth soon will work, it is very important to us that they work here, and thank you very much for participating.

The CHAIRMAN. Our final panel: Dr. Henry Williams, who is president of the Medical Chirurgical Society of the District of Columbia; Dr. Desmar Walkes, the staff physician of Health Care for the Homeless in the District of Columbia; Dr. Adrian Wilson, who is president of the Doctors Council of the District of Columbia; and Dr. Harold Weiss, who is president of the Medical Society of the District of Columbia.

Ladies and gentlemen, welcome to the committee. My light, in typical Walter Mitty fashion, is not working, and I would be remiss if I did not welcome to the podium our colleague from Texas, who has a particular interest.

Craig, would you like to introduce one of the witnesses?

Craig Washington, the Congressman from Texas, is here and has an interest in the proceedings today and might like to introduce one of our witnesses, and I am happy to recognize the gentleman from Texas for that purpose.

Mr. WASHINGTON. Thank you, Mr. Chairman.

I will just say this. You have on the panel a very fine physician who is very dedicated, and if I say any more then I am going to run into an even bigger family values problem.

The CHAIRMAN. Right. Thank you for joining us. We will let Dr. Williams lead off.

Please.

STATEMENTS OF HENRY WILLIAMS, PRESIDENT, MEDICAL CHIRURGICAL SOCIETY OF THE DISTRICT OF COLUMBIA; DESMAR WALKES, STAFF PHYSICIAN, HEALTH CARE FOR THE HOMELESS; ADRIAN G. WILSON, PRESIDENT, DOCTORS COUNCIL OF THE DISTRICT OF COLUMBIA; AND HAROLD WEISS, PRESIDENT, MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA

STATEMENT OF HENRY WILLIAMS

Dr. WILLIAMS. Thank you very much, Congressman Stark and members of the panel.

On behalf of the Medical Chirurgical Society I would like to extend our thanks for being asked to attend this distinguished Committee on the District of Columbia.

Many of the members of the Medical Chirurgical Society are members of the hospitals that you have visited and some of the HMO's and medical staffs that you have talked to. We would like to provide the services and continue the dialogue with the committee as well as the insurers and the hospitals in their service renderings.

We find ourselves very concerned about the access to health care. Our members, many are in the District's areas that are underserved, such as in wards 7, 8, and 5. We also have members that are in wards 1 and 2, which are where our medical school, Howard University, is mostly located. We have certain things that distract our members in their care giving, and one is, of course, the third party reimbursement systems, the tort reform systems that are in the District of Columbia, the availability of location for our members, and as you look at the medicaid/medicare systems that you were talking in terms of earlier there are some benefits in being in a rural situation that are not available to us in the urban areas, such as incentives to practice in that area, and we hope that is a consideration that would be looked at in the future as underserved areas are solicited.

We also have difficulty in patient availability and hospital affiliation, and some of us, because of locations or because of certain needs that we have, are not associated with hospitals that may work with one or other types of managed care systems. We do not

believe that the only system that should be looked at in managed care should be the capitation system, but case management systems that are available in other States would be certainly something that we would continue to endorse.

Our members are also sensitive to the educational needs of our students that are coming through medical schools as well as the cost that medical education is bearing. As an Afro-American physician, sometimes the cost of education is unduly burdened by our members. Therefore, when considerations are made we hope that medical education, the placement, the incentives for having Afro-American physicians become members of the medical staffs of various areas be taken in consideration for its cost and necessity and bearing the load of loans.

We also wanted to endorse the concept that the District of Columbia General Hospital is a training ground of our medical staffs. I, for one, have been a trainee of that institution, and I endorse the concept of its continued activity in the care of patients as well as a training mechanism.

I would like to again express our thanks for being allowed the opportunity to express my views in front of the committee and await your questions.

The CHAIRMAN. Thank you very much.

Dr. Walkes.

STATEMENT OF DR. DESMAR W. WALKES

Dr. WALKES. Good afternoon, Mr. Chairman, members of the committee, ladies and gentlemen.

I have prepared a written statement, and I ask that it may be made part of the record at this time.

The CHAIRMAN. Without objection.

Dr. WALKES. Thank you.

My name is Desmar Walkes. I am a general practitioner practicing here in the District of Columbia. I have been practicing since 1987 in private practice settings and in health maintenance organizations prior to coming to my current position, which is at Health Care for the Homeless Project. It is an organization that is a nonprofit, private organization that receives funding from various sources, including McKinney grant funding, Ryan White's 1 and 3 funding. We have contracts with the Commission on Public Health here in the District of Columbia. We receive funds from Comic Relief and grants. We deliver a comprehensive package of services to approximately 10,000 individuals in the District of Columbia who make up a portion of the homeless population here in the city. It is estimated that there are approximately 12,000 to 15,000 individuals who are homeless in the city.

We have community links for our patients to allow them to receive secondary and tertiary medical needs through the District of Columbia Commission on Public Health, the D.C. Commission on Mental Health, and the D.C. Commission on Social Services. We at Health Care for the Homeless have medical personnel that range from physicians, psychiatrists, social workers, physicians' assistants, and case management services. We also provide HIV testing and counseling and treatment for people with HIV and AIDS in

our clinics and have special services provided for these individuals at a day center where they can come during the day to partake of food, receive education and treatment, and also a 24-hour special needs center that takes care of patients with AIDS who have late stages of the disease.

We are happy to be asked to come to the table to contribute something to the discussion on health care reform in this country. We see it as a must, and we applaud your efforts.

Upon looking at the various plans that have been proposed, the managed care plan as you have outlined, Mr. Chairman, is something that would work probably for some of the general population, but in essence it lacks addressing the complexities of the population I serve. A lot of the plans require a residence for the people that are participating and would not work with the homeless.

The CHAIRMAN. You know, some reporter picked this up the other day, but I have been making—I only have one speech—making the same speech for years, and I have always said that one of my requirements for health reform would be that every resident have the right to medical care, and I picked that word for a very special reason. A reporter asked me the other day, he said, "Well, the President has been talking about every American as if maybe that meant citizen, and did you mean something different when you used the word 'resident?'" and I said, "Yes, I do; I mean resident, anybody who is here. I don't care whether they got off an unidentified flying object or how they got here, they are here, the same way we would be treated in Canada or England or Germany."

In Los Angeles and San Diego, we have a tremendous number of Mexican nationals, many of whom are there illegally, but under the antidumping laws emergency rooms cannot turn them away. I mean the law is today that they get treated. Unfortunately, I am not sure that they get the treatment in the best way. So, I really do mean, at least insofar as I have anything to say about it—resident—whether it is a temporary residence or whether they are living at Mitch Snyder Memorial Boarding House or wherever they are. It seems to me that we have to do that or the system falls apart.

Dr. WALKES. Well, that is wonderful to hear.

The CHAIRMAN. I would insist on it.

Dr. WALKES. So you are addressing the problem of access.

The CHAIRMAN. I am sneaking up on it.

Dr. WALKES. Sneaking up on it.

Then the other thing that concerns my group and others who provide services to the homeless is that of the money that is received that I listed earlier; 50 percent of our budget is based on McKinney grant funding, which has allowed us to provide the special services that I have outlined, and those we put into a category called outreach. I think that cannot be underscored enough; the need for outreach in this particular community is essential, and the success of our mission has been that we have been able to put clinics in shelters.

In the list of questions that you submitted for us to address, there was a question about whether or not we thought there would be more providers in a managed system to serve the underserved community. My answer to that question, as I heard from the gen-

tleman from Chartered, is, no; I don't think so. We are having a difficult time recruiting physicians to come and work in our group. So I think that needs to also be taken into account.

We have a mobile outreach van that goes out into the streets at night, for example, to the grates and the city parks to go where people who are homeless congregate. We do primary medical assessments there and then refer them appropriately to either our clinic sites or to the hospitals. So outreach is my second concern.

Something I would like to throw in for you to consider is the notion of GP fund holding or general practitioner fund holding mechanisms, such as those seen in Great Britain, where a general practitioner or a group of general practitioners with x number of patients in their patient portfolio would be given a yearly budget that they would use not to pay themselves salaries so much, but to pay for the medical services needed by their particular group of patients. I think if something akin to this were put into place in the health reform that you are going to be addressing in the future, we might be able to not need the McKinney grant funding and the other grant funding sources and the private contributions that we have to go out there and try to scrape together in order to achieve our goal.

Thank you.

The CHAIRMAN. Thank you very much.

Dr. Wilson.

[The prepared statement of Dr. Walkes follows:]

Health Care for the Homeless Project, Inc.
Washington, D.C.

Administrative Office
Vincent A. Keane
Executive Director
1234 Massachusetts Ave., N.W., Suite C-1009
Washington, D.C. 20005
(202) 628-5660
Fax: (202) 628-5719

Project Office
Christ House
1717 Columbia Road, N W
Washington, D C 20009
(202) 328-1100

TESTIMONY OF DR. DESMAR W. WALKES

ON BEHALF OF

THE HEALTH CARE FOR THE HOMELESS PROJECT, INC

WASHINGTON, D.C.

BEFORE THE HOUSE OF REPRESENTATIVES COMMITTEE ON DISTRICT OF COLUMBIA

MONDAY, APRIL 19, 1993

Introduction

Mr. Chairman, Members of the Committee, ladies and gentleman my name is Desmar Walkes. I am a general practitioner working as a staff physician for Health Care for the Homeless Project (HCHP), Inc.

Health Care for the Homeless is an independent, nonprofit organization dedicated to providing quality health care for Washington DC's homeless population. I have been practising medicine since 1987 in private practice settings in Virginia and before that in a Health Maintenance Organization, CIGNA, in Houston, Texas. I began working with HCHP in 1992. I practise in the House of Ruth shelter for women here on Capitol Hill. We see approximately 2000 patients per year.

In 1992, DC's homeless population was estimated to be from 12,000 to 15,000 people of which some 10,191 were seen in one of our clinics. There were 42,400 patient encounters project wide. Approximately one third of these clinic visits were HIV/AIDS related. It is estimated that in 1993 this figure for HIV/AIDS clinic visits will approach one half of the total of patient encounters.

Health Care for the Homeless Project, Inc.

HCHP is an independent, nonprofit organization which has been in existence since 1985 providing quality health care for Washington's homeless population. Our organization provides primary medical care, case management, psychiatric services and substance abuse counseling to approximately 10,000 homeless individuals and families. HCHP has a staff of 60 full time medical personnel including physicians, psychiatrists, nurse practitioners, nurses, medical assistants and case managers. We are currently operating 11 clinics in emergency shelters and a mobile outreach van which provides primary medical services, mental health assessments, referral and case management services to individuals who congregate in public parks, on street grates and in other non-shelter locations.

In recent years, HCHP has enhanced medical services to patients with Human Immunodeficiency Virus (HIV) and Acquired

Immunodeficiency Syndrome (AIDS). A specially-trained staff operates a Day Center for these patients providing primary nursing care, counselling, patient education, recreational therapy and nutrition enhancement. In 1992 a Special Care Unit was opened to provide 24 hour care to patients with advanced stages of AIDS.

Our organization has linkages with community resource groups and public sector agencies. Cooperative relationships exist with the DC Commission of Public Health, the DC Commission of Mental Health and the DC Commission on Social Services. These entities are the means by which we obtain access to secondary and tertiary medical and mental health services for the patients seen in our clinic.

HCHP Health Care Delivery System and the Shortfalls

I would say that the HCHP system more nearly approaches the single payer model of health care delivery. Financially, we exist through grant funding. Our current federal grants include a McKinney Grant; an HIV services grant - Ryan White III- Early Intervention and Treatment grant($476,160); and a Ryan White Title I grant($80,000).

Our McKinney grant is our single largest source of revenue and supports almost 50% of our work. The amount projected for FY93 is $1,616,862.

Other revenues sources include a contract with the Commission of Public Health($689,585), Comic Relief($175,00) and a Foothealth Foundation Grant($7,000) through the American Podiatric Medical Association.

The advantages of the HCHP structure, to me as a provider, are that I am not required to concern myself with the every day fiscal concerns of running a medical practice. Supplies, pharmaceuticals, wages, hiring and accounts receivable are handled through our main office. My concern is solely the provision and access of medical care to my patients.

I prescribe drugs from a formulary list of medications, can order any laboratory test available to the general population through laboratory and pathological services provided at no cost to us from a local hospital. Our clinic is in a room that is a quarter the size of this committee room.

This, on its face, appears to be ideal, and, in fact, we superbly manage the medical problems that do not require specialist care in our clinic. The problems with accessing specialist care are when this system falls short.

We have developed referral forms in our organization which delineate our clinical findings and outline what, if any, procedures we have performed during our workup of the patients. These are given to our patients as they go for their appointments with designated specialty medical service providers. We make the appointments for our patients and will give tokens to pay for their transportation costs. Then, it as though they enter a maze called the public health system.

We are experiencing difficulty in accessing the public health system for our patients. When the homeless lose their homes, they not only lose their shelter but many also lose their self-respect and dignity. These individuals may smell, or have lice. To some they are not desirable. They often have mental illness and impaired social skills. They may be rude. To say, at times, that interacting with these individuals requires a goodly amount of patience is true. However there must be respect for them as members of our society.

Analysis of the Health Care Reform Proposals

Managed Care System

The proposal for coverage through managed competition requiring the purchase of medical services through a regional purchasing cooperative is attractive. The problems that I see with this approach however, are the following:

- Will homeless persons be covered by the same Health Insurance Purchasing Cooperative (HIPC) as the rest of the general population?
  As I understand this system, employers and employees pay into the system which entitles them to receive a medical benefits package. The homeless will in many cases be unable to meet this requirement.

- Will a card or a place of residence be required to access the system? The access factor must be addressed for,

as in many European societies, residency requirements drive the homeless to the Emergency Rooms, a scenario similar to the circumstances in this country before McKinney grants were enacted to now provide health care services to homeless people in over 130 cities.

. Who will oversee the services provided to the homeless and indigent populations within this structure? Community based organizations who provide medical care to the homeless in this city help to decrease the use of Emergency Rooms and out-patient clinics in the public sector. There exist good interagency and intraagency communication regarding a patient's medical history. Without oversight, referral to a secondary or tertiary facility means patients often undergo unnecessary repeat testing and some patients are inappropriately discharged from hospitals.

. If managed plans are to be developed, what incentives will be put in place to encourage more physicians and health care providers to participate? The current Medicaid reimbursement rates and slow collection are disincentives to participate in the system. Our organization would not able to exist solely on these reimbursement levels due to the amount of outreach needed to serve the homeless.

. DC General Hospital is the mainstay for referral of our patients for specialist and emergency care. Currently a patient can wait from as long as two weeks to six months for an out patient clinic appointment.

. Will more funds be appropriated to analyze the problems which cause inordinate waiting times? Will more funds be appropriated for the necessary increase in personnel to serve the underserved?

The greatest shortcoming of the Managed Care system, as it relates to health care access and delivery to the homeless, is that it fails to address the special needs of this population and the subsequent need for outreach services that will not be needed in the general population. It will, therefore, be necessary to leave funding in place for organizations that provide health care and outreach services to the homeless through McKinney grants, or insure that these aspects of are adequately provided for in a managed care system.

All Payer System

In an all payer system, the issue of access is again important to the homeless. The notion of freedom to choose any physician is difficult to imagine for people who are not welcomed on our park benches. We should be mindful of the experience in England whereby the poor and homeless in East London were receiving inadequate medical care despite the large numbers of teaching institutions, medical specialists, and over 150 hospitals.

The primary benefit of an all-payer system is the use of current Medicare codes now used many medical practices and hospitals. The nation's medical community is already familiar with its nuances and a universal form would reduce administrative costs.

Single Payer System

Overall, the simplicity of this system is its greatest asset, as it will base its health care budget on the health of the nation's economy. Measures to curb rising pharmaceutical cost must be implemented as in the German national health insurance system in order to contain costs. German measures include:

- encouraging physicians to use medications from a formulary of approved drugs
- making available to Germany citizens newer and more costly drugs that have been proven to be more effective
- Making pharmaceutical companies and physicians pay for expenditures over a certain percentage of the pharmaceutical budget allocated for a given year.

The single payer system as it exist in England post-health care reforms, and the introduction of General Practitioner (GP) Fundholders, is another element necessary to effectively and efficiently serve the homeless in this country. The GP Fundholder system in England is a system whereby physicians who register as GP Fundholders are given a yearly budget with which to provide medical services to their patients. This GP Fundholding system could take the place of the current Mckinney grants if adequate risk assessments were performed, making funding available for special communities like the homeless. Factors such as outreach in the homeless community, better provision of community-based

services could be included in assessing the funding needs of the homeless.

Summary

In summary, the success of HCHP and other organizations across this nation that provide health care to the homeless is based on our patients' easy access to our clinics and our aggressive outreach to those who are in need. We see the need for universal health insurance coverage for all in this country as necessary for the homeless to receive comprehensive care without the additional stigma of a person who is unable to pay for what should be the right of all citizens in a democratic society that promises life, liberty, and the pursuit of happiness.

STATEMENT OF DR. ADRIAN G. WILSON

Dr. WILSON. Thank you, Mr. Chairman. Good afternoon, Chairman Stark and members of the committee.

I am Dr. Adrian Wilson, president of the Doctors Council of the District of Columbia. The Doctors Council is a labor union representing dentists, physicians, and podiatrists employed by the District. Our members provide front-line medical care for the District's ambulatory care clinics, St. Elizabeth's Hospital, mental health clinics, nursing homes, and drug and alcohol treatment facilities, and the corrections facilities of the District.

Studies are published year after year which reveal that the District leads the country in the highest infant mortality, oral cancer, and preventable death rates, and our members confront the realities of these statistics each day in our clinics. Regardless of the label applied to the inevitable health reform, we as public health clinicians believe that its success will depend on the general key elements, several elements.

Reform must have as its primary goal the improved health of our community. Any system designed primarily to save money will most certainly fail in every respect. If anything, the District health care is currently underfunded. Health care reform must assure universal access and comprehensive coverage. With the worst health statistics in the country, the District needs to pay more focused attention tc our community. Any reform which provides a low-base line of coverage to which one might add if one has the financial resources would automatically cut out our most health needy citizens.

Access must include coverage for dental services and nursing home dental care. The District's refusal to cover these critical health services under medicaid has contributed to our high rate of mortality from oral cancer as well as the delayed diagnosis and treatment of other diseases which often manifest themselves first in the oral cavity.

Access must include preventative care services as well as mental services as well as long-term services. Access must also include the strengthening of the neighborhood clinic network. The community clinics are a trusted health resource which the District has continuously underfunded and underutilized. This has cost the District dearly and increased emergency room and hospitalization costs.

Health reform must ensure that the clinics become fully staffed as health wellness centers which provide preventative services to our community. Health care reform must place a high priority on provider choice in order that the critical relationship between the patient and the doctor are fostered. The contribution of this relationship to the improved health and well-being of the patients should not be underestimated.

The provision of public health services is a time-consuming process. Our community requires health education, aggressive followup, and home-care services and other specialized health services if we are to recapture the long-term health of our community. We feel that because of the time required to follow patients with adverse health profiles, the managed care concept is not a feasible model

for the District. Managed care's track record has been less than a success in the District's medicaid population.

First, managed care has not changed the District's health statistics. Second, at least one quarter of the current enrollees return back to their neighborhood clinics for care often for an environment and provider whom they know and trust. Third, managed care providers have not taken the time needed to aggressively provide health care education and followup.

With our troubled population, health care professionals must aggressively draw patients into the medical and dental facilities for the preventive education and treatment. Finally, there is no reliable evidence from any source, including the Congressional Budget Office, that managed care has significantly reduced the health care costs or improved access. This is not the model to rely on for turning the tide on the District's health care problems.

In summary, District health care reform must be used as a means to assure access to comprehensive health care for all D.C. residents. Health care workers must have the time and the clinical autonomy to provide the preventive care and health education which will reap generational benefits to this community. We would favor a plan which provides the elements I have described and which converts current excessive administrative costs to direct care funds. The Doctors Council stands ready to work with you toward this goal.

Thank you for this opportunity to address the committee today.

The CHAIRMAN. Thank you very much.

Dr. Weiss.

[The prepared statement of Dr. Wilson with attachment follows:]

DOCTORS COUNCIL
1101 VERMONT AVENUE, N.W., SUITE 405, WASHINGTON, D.C. 20005 (202) 408-3373 FAX: (202) 408-339

STATEMENT OF DR. ADRIAN G. WILSON, PRESIDENT OF THE DOCTORS COUNCIL

OF THE DISTRICT OF COLUMBIA, BEFORE THE U.S. HOUSE COMMITTEE

ON THE DISTRICT OF COLUMBIA.

APRIL 19, 1993

Good morning, Chairman Stark, and committee members. I am Dr. Adrian Wilson, president of the Doctors Council of the District of Columbia. The Doctors Council is a labor union representing dentists, physicians, and podiatrists employed by the District. Our members provide front line medical care in the District's ambulatory care clinics, St. Elizabeths Hospital, mental health clinics, nursing homes, drug and alcohol treatment facilities, and in the correctional facilities. Studies are published year after year which reveal that the District leads the country in the highest infant mortality, oral cancer, and preventable rates; our members confront the reality of these statistics each day in our clinics.

Regardless of the label applied to the inevitable health reform, we as public health clinicians believe that it's success depends upon several key elements.

Reform must have as its primary goal the improved health of our community. Any system designed primarily to save money will most certainly fail in every respect. If anything, District health care is currently under funded.

Health care reform must assure universal access and comprehensive coverage. With the worst health statistics in the country, the District needs to pay more focussed attention to our community. Any reform which provides a low baseline of coverage to which one might add if one has the financial resources will automatically cut out our most health needy citizens. Access must include coverage to adult dental services and nursing home dental care. The District's refusal to cover these critical health care services under medicaid has contributed to our high rate of mortality from oral cancer; as well as to the delayed diagnosis and treatment of other diseases which often manifest themselves first in the oral cavity. Access must include preventive care services, as well as mental health services, and long term care. Access must also include the strengthening of the neighborhood clinic network. The community clinics are a trusted health resource which the District has continuously under funded and under utilized. This has cost the District dearly in increased emergency room and hospitalization costs. Health reform must assure that the clinics become fully staffed health wellness centers which provide preventive services to our community.

Health care reform must also place a high priority on provider choice, in order that the critical relationship between patient and doctor be fostered. The contribution of this relationship to the improved health and well being of the patient should not be underestimated.

The provision of public health services is a time consuming process. Our community requires public health education, aggressive follow up, home health care services, and other specialized health services if we are to recapture the long term health of our community; we feel that because of the time required to follow patients with adverse health profiles, the managed care concept is not a feasible model for the District. Managed care's track record has been less than a success to the District's medicaid population. First, managed care has not changed the District's health statistics. Second, at least one quarter of current enrollees return back to their neighborhood clinic for care, opting for an environment and provider whom they know and trust. Third, managed care providers have not taken the time needed to aggressively provide health education and follow up. With our troubled population, health care professionals must aggressively draw patients into medical and dental facilities for preventive education and treatment. Finally, there is no reliable evidence from any source, including the Congressional Budget Office, that managed care has significantly reduced health care costs, or improved access. This is not the model to rely upon for turning the tide on the District's health problems.

In summary, District health care reform must be used as means to assure access to comprehensive health care for all DC residents. Health care workers must have the time and clinical autonomy to provide the preventive care and health education which will reap generational benefits to this community. We would favor a plan which provides the elements I have described, and which converts current excessive administrative costs to direct care funds.

The Doctors Council stands ready to work with you toward this goal.

Thank you for this opportunity to address this committee today.

Doctors Council of the District of Columbia
Adrian G. Wilson, DDS
President
1101 Vermont Avenue, N.W.
Suite 405
Washington, DC 20005
(202)408-3373

Contact:
Lori Calderone
Staff Representative
(202)408-3373

Statement Summary

I. Doctors Council composition
   1. DC government physicians, dentists, podiatrists;

II. Requirements of health reform
   1. Primary goal to improve District citizens health;
   2. Universal access, coverage, including adult dental, preventive care, mental health;
   3. Provider choice.

III. Problems in managed care
   1. No evidence of cost savings
   2. No evidence of improved health results or improved access

STATEMENT OF HAROLD WEISS

Dr. WEISS. Good afternoon, Congressman Stark and members of the committee.

I am Harold Weiss, president of the Medical Society of the District of Columbia, which represents over 3,500 physicians who work and/or live in the District of Columbia. I am also an internist and pulmonary physician at Providence Hospital in the northeast sector of town, and I am involved with the training program of internal medicine in that institution.

The Medical Society is grateful that you are holding these hearings and showing such strong interest in health policy as it relates to the District. Let me open by saying that in light of the national focus on health care reform, MSDC has begun to revisit its own policy on comprehensive health care and will be finalizing its official policy later this month.

MSDC has been a leading advocate of health care reform in the District and has made formal presentations regarding comprehensive health coverage of the District residents in each of the last two D.C. Council periods. I believe that you were a participant in the most recent hearings before D.C. Council member John Ray's D.C. Consumer and Regulatory Affairs Committee as well.

In the past, our proposal for reform has been based on the American Medical Association's Health Access America Program, which primarily calls for universal access to health care via insurance offered by employer mandate. MSDC has adopted almost all of its principles, with the exception of repeal of State mandates. Our primary reason for our diversion with the AMA on this issue is due to the increased need in special areas of the District's population, in areas such as mental health and substance abuse, well child care, breast cancer screening, as well as others.

The District is different than all other jurisdictions in the country. Its population is almost exclusively urban, predominantly black, and includes a significant number of low-income patients. The health care needs in the District are strongest when it comes to special health care reform needs such as preventive care, substance abuse, mental health, cancer-related diseases, infant mortality, the spread of AIDS, increase in tuberculosis, and other related diseases in addition to its large population of uninsured and underinsured residents. Any program targeted at comprehensive reform must address these areas in a serious fashion if it aims to address the health needs of District residents.

Regarding cost containment, our health care reform proposal has also included adoption of medical malpractice reform. Physicians in the District are unfairly subject to overwhelming insurance premiums that serve as an incentive for them to take their practices elsewhere, especially in this era of health care reform, when controlling costs is such a priority. The cost of malpractice insurance continues to increase in the District mainly because of lack of action by the D.C. Council on this issue. We have sought legislation in this area since 1974, before home rule, and the D.C. Council has yet to even vote on this kind of legislation.

Over the past decade, we have seen the number of doctors triple in northern Virginia and practically double in surrounding Mont-

gomery and Prince Georges Counties while, outside of expansion on hospital grounds, the number of physicians in the District has decreased. Both Maryland and Virginia have adopted medical malpractice reforms. Maryland, in fact, strengthened its laws during the most recent general assembly session.

These chronic health problems will not be reduced if there are not adequate numbers of physicians treating patients. This measure has not only the support of medicine, including the D.C. Hospital Association, the D.C. Nurses Association, and the D.C. Association of Health Maintenance Organizations, and also groups ranging from the National Commission to Prevent Infant Mortality, the Better Babies Project, the D.C. Federation of Civic Associations, Kiwanis, the Archdiocese of Washington, the Zaccheus Free Clinic, and the D.C. Act-Up, to name a few. Howard University President Dr. Franklyn Jenifer gave testimony before the D.C. Council in support of the bill.

This is not just an issue about doctors and other health care providers. Broad segments of Washington, DC., support the current medical malpractice reform bill, 10–5, the D.C. Health Occupations Revision Act of 1985, Amendment Act of 1993, pending in the District. The D.C. Council, in spite of this broad support, remains unmoved and continues to place this issue on the back burner. If significant malpractice reform, which includes limitations on recovery of noneconomic damages of $350,000, which is the current Maryland limit, is not adopted by the D.C. Council or by Congress, patients will continue to suffer problems with access to health care in the District and more physicians will leave the District.

Cost containment has often been presented in the form of managed care and competition. While there are some positive aspects to different types of delivery systems, no one system should be promoted over the other. Much of managed care's expenses end up in administrative costs, including utilization review and other types of similar activity, instead of in health care delivery. We have had a long concern that managed care often turns out to resemble managing cost as compared to care, thus affecting the quality of care that patients receive. Even the HHS inspector general questioned the wisdom of spending $13.3 million to save $1.4 million in unnecessary care. Questions regarding real expenditures of health care dollars in managed care should be examined by this committee.

Reduction of administrative costs is a major factor in cost containment. This includes reducing the antihassle factor among providers and standardizing claims forms. Until we can get some handle on the demand for medical care, our costs will not come under control. We need to make use of preventive medicine. We need to reduce the impact of violence, the impact of substance and drug abuse, on our health care system. Without it, demand will continue to drive the system.

Additionally, patients should have the freedom of choice to choose not only their health care system but their own provider of health care as well. Physicians, in turn, should have the right to earn a living in the manner they see fit and are most comfortable. Our support for any managed competition proposal is reliant upon support of certain principles, including relief from existing antitrust laws with respect to the right of physicians and physician or-

ganizations to engage in group negotiations with purchasers, managed care entities, and third-party payers on issues of clinical autonomy, quality, and costs; and, to modification of ERISA laws to provide for the appropriate regulation of self-insured health benefit programs; three, adequate physician representation on any board or commission established as part of a managed competition plan; and, four, preservation of freedom of choice for patients to choose their doctor and providers, choose their method in earning a living.

MSDC would not support any proposals enacting either price controls or strict global budgets. They have been tried in the past, and they simply do not work. Upon review and approval of our board of trustees, I will be happy to forward our revised policy on health care reform to the committee.

In regard to the questions that were posed, I would like to comment on just two. As far as managed competition, the impact would depend on the benefits of the package, the reimbursement provided to physicians under the package, the access that patients have to the provider of their choice, coupled with the access that providers have to managed care networks under the program.

In addition, if any managed care proposals do not adequately deal with the hassle factors that physicians face every day, then physicians will continue to spend more time fighting with administrators rather than treating patients. Our own experiences suggest that managed care has served to increase daily administrative costs and hassles for physicians rather than decrease them.

Finally, I must say a word about D.C. General. I did my internship there. I went back for a fellowship in pulmonary medicine, and I everyday feel very proud of the training they provided me. D.C. General has served as a safety net for many in need of health care in the District. The population is heavily dependent upon health care services that D.C. General provides, a very difficult population to manage, and any discussion of health care reform must take into account the burden of uncompensated care that inner-city hospitals would have to provide. The closure of D.C. General would result in a reduction of approximately 400 acute beds which would put a strain on nearby hospitals forced to take up the slack.

Thank you again for the privilege of addressing you.

[The prepared statement of Dr. Weiss with attachment follows:]

Medical Society of the District of Columbia

Testimony of

Harold Weiss, M.D.
President of the
Medical Society of the District of Columbia

on health care reform

before the
US House of Representatives
Committee on the District of Columbia
Rep. Fortney P. Stark (D-Calif.), Chairman

on Monday, April 19, 1993

1707 L Street, N.W., Suite 400
Washington, D.C. 20036
(202) 466-1800
FAX (202) 452-1542

Good morning, Congressman Stark and Members of the Committee. I am Harold Weiss, M.D., President of the Medical Society of the District of Columbia (MSDC). The Medical Society represents over 3,500 physicians who work and/or live in the District of Columbia.

MSDC is grateful that you are holding these hearings, and showing such strong interest on health policy as it relates to the District. Let me open by saying that in light of the national focus on health care reform, MSDC has begun to revisit its own policy on comprehensive health care, and will be finalizing its official policy later this month. MSDC has been a leading advocate of health care reform in the District, and has made formal presentations regarding comprehensive health coverage of District residents in each of the last two DC Council periods. I believe that you were a participant in the most recent hearings before D.C. Councilmember John Ray's Consumer and Regulatory Affairs Committee as well.

In the past, our proposal for reform has been based on the American Medical Association's "Health Access America" program, which primarily calls for an employer mandate. MSDC has adopted almost all of its principles, with the exception of repeal of state mandates. Our primary reason for our divergence with the AMA on this issue, is due to the increased need in special areas of the District's population, in areas such as mental health and substance abuse, well-child care, breast cancer screening, as well as others. The District is different than all other jurisdictions in this country. Its population is almost exclusively urban, predominantly black and includes a significant number of low-income patients. The health care needs in the District are strongest when it comes to special health care reform needs such as preventive care, substance abuse, mental health, cancer-related diseases, infant mortality, the spread of AIDS and other related diseases, in addition to its large population of uninsured and underinsured residents. Any program targeted at comprehensive reform must address these areas in a serious fashion if it aims to address that health care needs of District residents.

Regarding cost containment, our health care reform proposal has also included adoption of medical malpractice reform. Physicians in the District are unfairly subject to overwhelming insurance premiums that serve as an incentive for them to take their practices elsewhere, especially in this era of health care reform when controlling costs are such a priority. The costs of malpractice insurance continues to increase in the District, mainly because of lack of action by the DC Council on this issue. We have sought legislation in this area since 1974 (before Home Rule), and the DC Council has yet to even vote on this kind of legislation. Over the past decade, we have seen the numbers of doctors triple in Northern Virginia, and practically double in surrounding Montgomery and Prince George's counties, while outside of expansion on hospital grounds, the numbers of physicians in the District has decreased. Both Maryland and Virginia have adopted medical malpractice reform measures (Maryland, in fact, strengthened their laws during the most recent General Assembly session).

These chronic health problems will not be reduced if there are not adequate numbers of physicians treating patients. This measure not only has the support of medicine, including the DC Hospital Association, the DC Nurses Association, and the DC Association of Health Maintenance Organizations, but also groups ranging from the National Commission to Prevent Infant Mortality, the "Better Babies Project," the DC Federation of Civic Associations, Kiwanis, Inc., the Archdiocese of Washington, Zaccheus Free Clinic, and DC Act-Up, to name a few. Howard University President Dr. Franklyn Jenifer gave testimony before the DC Council in support of the bill. This is not just an issue about doctors and other health care providers; broad segments of Washington, DC supports the current medical malpractice reform bill (Bill 10-5, the " D.C. Health Occupations Revision Act of 1985 Amendment Act of 1993") pending in the District. The DC Council, in spite of this broad support, remains unmoved, and continues to place this issue on the back burner. If significant malpractice reform, reform which includes limitations on recovery of non-economic damages of $350,000 (the current Maryland limit) is not adopted by either the DC Council or by Congress, patients will continue to suffer problems with access to health care in the District, and more and more physicians will leave the District.

Cost containment has often been presented in the form of managed care and competition. While there are some positive aspects to different types of delivery systems, no one system should be promoted over the other. Much of managed care's expenses end up in administrative costs, including utilization review and other types of similar activity, instead of in health care delivery. We have had a long concern that managed care often turns out to resemble "managing cost" as opposed to care, thus affecting the quality of health care that patients receive. Even the HHS Inspector General questioned the wisdom of spending $13.3 million dollars to save $1.4 million dollars in unnecessary care. Questions regarding real expenditures of health care dollars in managed care should be examined by this Committee.

Additionally, patients should have the freedom of choice to choose not only their own health care system, but their own provider of health care as well. Physicians, in turn, should have the right to earn a living in the manner they see fit and are most comfortable. Our support for any managed competition proposal is reliant upon support of certain principles including: (1) relief from existing antitrust laws with respect to the right of physicians and physician organizations to engage in group negotiations with purchasers, managed care entities, and third party payors on issues of clinical autonomy, quality and costs; (2) modification of ERISA laws to provide for the appropriate regulation of self-insured health benefit programs; (3) adequate physician representation on any board or commission established as part of a managed competition plan; and (4) preservation of freedom of choice for patients to choose their doctor, and providers to choose their method in earning a living. MSDC would not support any proposals enacting either price controls or strict global budgets. Price controls have been tried in the past, and they simply do not work. Upon review and approval by our Board of Trustees, I will be happy to forward our revised policy on health care reform to the Committee.

With regards to your questionnaire, MSDC provides the following responses to your questions:

On Managed Competition:

1. The impact would depend on the benefits in the package, the reimbursement provided to physicians under the package, the access the patients have to the provider of their choice coupled with the access that providers have to managed care networks under the program, and the specialty of the physician's practice. In addition, if any managed care proposals do not adequately deal with the "hassle factors" that physicians face every day, then physicians will continue to spend more time fighting with administrators rather than treating patients. Our own experiences suggest that managed care has served to increase daily administrative costs and "hassles" for physicians rather than increase them.

2. Providers will not locate in certain areas to practice in the District until the malpractice question is adequately addressed. Primary care providers increasingly cannot afford to take the risk of providing care to high-risk populations and pay exorbitant malpractice premiums. After a certain period of time, it is not cost-effective to provide that much care in underserved areas. As a physician, you begin paying to provide those services, rather than being reimbursed for those services.

3. We do not believe that with the current restraints on the District's budget, coupled with the historically inadequate levels of reimbursement for Medicaid, that capitation will serve to bring more physicians into providing care for Medicaid patients. The level of payment would not begin to approach a proper level for the level of care needed to provide health care at a reasonable cost.

4. Access to the District's Medicaid program will continue to be hindered as long as reimbursements remain low. While I cannot speak on reactions of patients to being in managed care, I can say that generally, patients want more access to physicians than they have. Increased physician reimbursement and reductions of overhead costs (such as malpractice premiums) must be addressed in a serious manner if access is to be increased.

5. As I have stated previously, access to care for patients will not be increased until the issues involving malpractice and other administrative costs and "hassles" are adequately addressed. These experiences might stress the importance of coordination of health care for those patients who are not in a system of care, as well as the increased health care needs for low-income District patients in certain areas. A "basic" plan in a managed care program has historically not addressed certain issues comprehensively, such as cancer-related diseases, AIDS, substance abuse, infant mortality, and other indices where the District lags behind other states.

6. DC General Hospital has served as a safety-net for many in need of health care in the District. The population that is heavily dependent upon health care services that DC General provides is a very difficult population to manage, and any discussion of health care reform must take into account the burden of uncompensated care that inner-city hospitals have to provide. We strongly oppose closure of DC General Hospital. Hospitals are suffering serious financial consequences because this issue is not being addressed. I will also add that physicians are also providing a great deal of charity care in the District, and that has served as a burden to our physician population as well.

On All Payor "Pay" or "Play"

1. We believe that employers should "play" in the new health care system, but not be given the option to "pay." The option of paying would be too strong an incentive for employers to avoid complying with necessary benefits for the general population. So many individuals would be covered if coverage was mandated for employees; it would be counterproductive to offer such a strong incentive to do otherwise. If universal coverage were available for all citizens, you would probably see an increased demand for health care by consumers, as well as an increase in volume of patient care for practitioners. This increased volume would likely increase overall spending on health care.

   I would add that as you increase the need for volume, without addressing other administrative costs, the time that a physician spends with his/her patient will decrease. This will only result in decreasing the quality of medical care that patients receive.

2. Mandating Medicare rates would devastate the great majority of most of the physician practices of District residents, as would be a dramatic blow to health care for District residents. This would be the case in spite of the exceptions proposed in your question.

3. It depends on what average that you're talking about. The "conversion factor" for the RBRVS fee schedule for the District is inadequate, and if this were duplicated for the private sector, the impact on District providers would be substantial. Again, the specific overhead costs that District physicians must pay must be addressed seriously by a national plan.

4. We do not believe that you can achieve improved access and real cost containment with the options presented. A better method of achieving these goals would be to follow the principles outlined in the AMA's "Health Access America" proposal that stresses freedom of choice for patients and physicians, significant medical malpractice reform, real administrative costs savings, physician input into quality issues, and access to care for all individuals. These goals would be accomplished without affecting either the quality of health care that patients receive, or the stability of the health care system.

   Attempting to achieve both goals with the options proposed would have serious consequences on both access to care, quality of care, and would fail to achieve real savings.

On Single Payor Medicare For All

We do not believe that a single payor system would benefit physicians in any manner. The government would be moving into an area that can and should be handled by private industry. We see no evidence that the government would serve to reduce administrative costs and/or "hassles" in any sense. In fact, these costs would likely increase in a single payor system.

Thank you once again, Congressman Stark, for holding these hearings. I will be glad to answer any questions that you have on my comments.

Summary Sheet

Dr. Harold Weiss
Medical Society of the District of Columbia

1707 L Street, NW
Suite 400
Washington, DC 20036
202-466-1800

Outline of Comments

1. MSDC generally supports the American Medical Association's "Health Access America" proposal as a means to lower costs and increase access.

2. The importance of medical malpractice reform to be included in health care reform.

3. Efforts taken to achieve malpractice reform in the District of Columbia.

4. Comments on managed care and managed competition.

5. Specific answers to questions proposed by the Committee: Managed Competition; Pay-or-Play; Single Payor)

The CHAIRMAN. Doctor, you and I have a problem, not the District of Columbia issue here, but I hear you loud and clear about malpractice.

Dr. WEISS. Thank you.

The CHAIRMAN. That is pretty easy for us to change, but it is not going to be as good as you think. We have a pretty good bill in California, and malpractice premiums are still going up. It really does not solve the whole problem.

But you and the AMA tell us that you are not going to support any proposal with price controls or a strict global budget, so I will tell you, I am not going to give you any malpractice reform until you agree to some kind of price controls or budget. How is that? So we have some negotiating to do, you and me, between getting from where we are today and where we are going.

Now that does not really have anything to do with today's topic, but it is a major parting of the ways between what I would refer to as organized medicine and how much money we have left in the country, probably because politicians spent too much. But that is going to have to be something that—we will wait and see what the President suggests. We are going to have a change in the malpractice laws that I think you will like. But we always figure that is the dessert, you have to eat your spinach, and that is going to help us save money. I am not quite sure how we do that without a budget or something else.

But what we have to deal with is the issue now of taking care of in the District 200,000 and some odd people. I am looking for my numbers chart here. If you think about it, out of the 600,000 people, about 200,000—maybe a little more, 250,000—are really in the Federal employees health benefit plan, the same one Dr. McDermott and I are in, and most of the District employees are in the holdover of that plan, and I would imagine—well, I know that. That is around 200,000 people.

So, there is that plan, which you could call, I suppose, a kind of HIPC. You have 80,000 medicare beneficiaries and 100,000 medicaid beneficiaries. So, basically we have two-thirds of the 600,000 people in this District in some kind of government operated and prescribed plan now, where basically we set either minimum benefits or the rates. We do have then the remainder, about 230,000 people, without insurance or medicaid beneficiaries who often have trouble qualifying or do not know how to qualify, and that is really the topic today.

You heard me suggest my solution, which is rather clumsy and that says let's just put everybody into medicare, and then all we have to fight about is how much we pay and whether you can have extra billing for private patients. But we all know what those rules are, and if everybody were in the District, that would be one way.

Dr. McDermott has a plan which would just say let's increase the income tax in the District of Columbia, put all the Federal employees under it, and have a single payer plan, which would then negotiate with all of you individually for either rates, fees or if you were practicing through a group practice, as Dr. Walkes is, we would pay that group a certain contracted amount, I would imagine, and none of the beneficiaries, none of the residents of the Dis-

trict, would have any concern other than figuring how to pay their taxes.

I am not sure that any of those plans will end up as the plan that the President will submit to us or will find its way through Congress. It may be an amalgam of some of those. Managed competition we have not defined yet or it has not been defined to us. It is some kind of bidding, I suppose, for putting everybody in a capitated plan, but I do not think Dr. Weiss is going to like that; I do not think Dr. Williams' group would like having to say they have to go and get all of their patients from some local cooperative office. I think physicians want to have some selection in whom they would choose to treat and not choose to treat.

So my question basically is, in the District, recognizing that we have a strange mix of very high income, comfortably compensated people, both professional who do not work for the Government and those who work for the Government; many families have a comfortable income. Then we have a third of our population who are among the poorest in the country and for whom access is not readily available. What do we do? Is there one plan that works? Just keep doing what we are doing?

We have seen the statistics here. In wards 7 and 8, we have a grand total of 118 docs down there out of your 3,500 members. What can we do, Dr. Weiss, to encourage a couple of hundred more? How do we get them down there? Just open our own clinics—the District I am speaking of now—and pay a decent salary, whatever it takes to get people down there and operate clinics? How do we do it?

Dr. WEISS. You have to provide incentives for physicians, particularly the young physicians coming out of our three medical schools who wish to go down and practice in underserved areas. You have to keep in mind that such physicians are coming out of medical schools with anywhere from $50,000 to as high as $100,000 in debt. They have to pay that debt. That is a real fact of life. You cannot mandate that they go into an area where reimbursement will barely meet their practice costs.

The CHAIRMAN. What can they get today in the Washington area? Let's say they come out of one of our medical schools here and they have completed a general or family practice residency. They want to go to work for somebody for a salary—Kaiser or whoever else, Dr. Wilson's group representing the government, if they are paid for by the D.C. government directly. What is the starting salary for one of those people today? Does anybody know?

Dr. WILSON. Approximately $70,000.

The CHAIRMAN. Seventy thousand for a family practitioner or general practice.

Dr. WEISS. It is very competitive. It changes with the specialist, internist versus family physician.

The CHAIRMAN. No; I understand.

Dr. WEISS. It changes with the plans, depending on the demand that they foresee for that physician.

The CHAIRMAN. If that person decides to go into radiology, what can they start out making if they have to go for a salary or work with a group?

Dr. WILSON. Approximately $20,000 more.

The CHAIRMAN. More, so there is that incentive. That pays off their loans in 4 or 5 years. But they could anticipate in the long run how much higher increase in earnings?

Dr. WILSON. There is a cap for the D.C. employee, and they are right at the max when they come in.

Dr. WEISS. But I think that you can expect that radiologists and pathologists will, in their lifetimes, earn considerably more than the primary-care physicians that we are talking about. So the incentive for young doctors to go into those areas, even if they elect to work for managed care programs, is going to be much higher than the incentive to do primary care particularly in underserved areas. Now we need to do something to change that mix, something that says to a primary-care trainee and physician, down to those areas, we are going to do things for you that will encourage you to practice in those areas. These are high-risk areas; patients are sick. We already talked about the need for malpractice reform. That has to be number one, because they are going to be faced with high-risk patients.

Number two, you have to find some way to increase reimbursement from whatever plan we use, whether it is from a Federal plan or any of the managed care programs. Reimbursement has to at least be inclusive enough to provide for their practice costs and a reasonable income. Current plans do not do that, so you have to have a mixture of private pay patients and federally subsidized patients to make a go of it. That is part of the problem.

The CHAIRMAN. Dr. McDermott.

Mr. MCDERMOTT. I want to ask a question. Several of you have suggested that the single-payer system does not hold any appeal, and I want to hear you explain to me what you believe is wrong with the single-payer system so I can understand the argument against it. What is it that the single-payer system does that is bad for the patient?

Dr. WEISS. Well, let's look at the figures that we got from the chairman. We have 380,000, maybe 400,000, people in the District who are already covered under some sort of plan sponsored by or run by the Federal Government. We do not see much reduction in cost from those plans. We see continued high costs, we see increased regulations, and administrative hassles.

Mr. MCDERMOTT. Let me stop you there. Let's never mind reducing costs for a second. Do you have some objection to extending the same benefits that all Federal employees have to all people in the District?

Dr. WEISS. Depending on what those benefits are. If they are inclusive to the things we think should be included in the District—mental health, substance abuse—then no; we have no problem with that.

Mr. MCDERMOTT. So, a single-payer system that had a generous benefit package would not be a problem?

Dr. WEISS. The benefits package would not be a problem. I am not talking about the single payer. If the benefits package offered to the city——

Mr. MCDERMOTT. OK. So we have factored out the benefit package. We agree that we want a generous benefit package. Now what

is wrong with a single-payer system as a way of financing that generous benefit package?

Dr. WEISS. From the experience we have had, this does not demonstrate that will control costs. It usually ends up, as it has in the Federal system, with increased regulation, increased hassle, so that it does not address the needs of our providers. We want to reduce the hassles, we want to reduce the administrative costs. The single-payer system has no track record that has shown that.

Mr. MCDERMOTT. Where has it been tried in the United States, the single-payer system?

Dr. WEISS. Well, we are talking about the Federal system as it applies to those patients, a percentage of patients that we deal with in the District——

Mr. MCDERMOTT. Well, the problem, Doctor, it seems to me, is that when you are dealing with a system where you are only dealing with some segment of the patients, you have no way to control the costs, so the single-payer system as we know it in this country really is never a single payer. You are always having costs shifted on to you, so that you can't control costs. If you only have 30 percent or 40 percent of the market, there is no way to control the costs if you have other people with the ability to push the costs off on to you through the hospitals, the last panel. Isn't that correct?

Dr. WEISS. We see as the major driving factor in cost not whether it is a single payer or not, it is the demand for care. If the demand continues to increase, whether it is a single payer or not, the costs will continue to rise, and then you still pay a price for the high administrative costs by the Federal Government without any indication that demand will be controlled.

Mr. MCDERMOTT. Then the managed competition, how will the demand be controlled in that system?

Dr. WEISS. If the managed care systems with minimum benefit packages included preventive care, substance abuse, education programs, it may not take a year, it may not take 2 years, but eventually demand will come under control.

If you have unchecked factors of domestic violence and street violence as we have heard today, and if that continues to rise, the impact on cost will continue. Until those factors really come under control, until the public, whether it be under a single payer or multiple payers or managed care, comes to recognize that they can't have all the services for all their needs at all stages of life, the costs aren't going to come under control irrespective of the system, and you pay a price then for a single-payer system with a higher administrative cost and the hassles without any real promise that you are going to get a handle on costs.

Mr. MCDERMOTT. I guess I do not think the experience of all the other industrialized countries of the world support that contention. But I think that Germany and some others will show that we are spending 25 percent more in administrative costs.

Another issue: That is the practice of malpractice insurance. I paid for that for a whole lot of years, and I used to wonder if you changed the law and you reduced my malpractice fees by $5,000 a year, where would that money go in the health care system? It would go into my pocket, wouldn't it? How would that reduce costs for the system? I never figured that out; what I would do different-

ly in my practice if I could drive down the costs of my insurance premium. Explain for me, you have other specialties than mine. Maybe I would do something different.

Dr. WEISS. It is clear that a good number of physicians will be employed or have their practice cost borne by managed care companies, the government, the university systems. Much of the malpractice insurance that is paid under those systems are paid by those payers.

Think of all the care you can provide for uninsured or fully insured individuals if managed care programs, instead of paying premiums as they are now, could divert some of those funds to programs for the uninsured or for education.

Mr. MCDERMOTT. So it would be in the managed care system or the managed competition system as you drove down the costs of malpractice, you would have this additional money by which you could cover other people. You could then use it to cover additional patients.

Dr. WEISS. This would be the ideal. It doesn't end up in the pockets of the administrators of the system, but goes toward the care of the patient.

Mr. MCDERMOTT. It would not change the practice one bit. What you are really saying to me is that you reduce the malpractice costs. That is not going to change the way doctors practice medicine at all.

Dr. WEISS. It absolutely would.

Mr. MCDERMOTT. It would? How would it do that? What would you do differently if you were paying 25 percent less in malpractice costs?

Dr. WEISS. The climate of malpractice reform colors everything that we do in the day-to-day practice of medicine: The tests that we need to order, the services that we need to render are covered in large amount by the threat of malpractice. It is not just defensive medicine, it is the threat, the implied threat of lawsuits.

With the high costs, that drives a good part of what we do in medicine. Reduction of that could be used toward better benefits.

Mr. MCDERMOTT. Well, I have trouble with that answer and I will keep asking it. Maybe somebody will explain to me how doctors really would change their behavior. But I think in most instances people practice medicine that they have been taught and they practice that kind of medicine without regard to their malpractice.

I understand the argument. I have been around the scrub rooms of hospitals enough to know what people say. But, on the other hand, I am not sure how it would change it.

Dr. WALKES. I do not think that reducing the cost of malpractice insurance is going to bring about the changes that you are speaking about. I think we need to go back to the question of medical training and address the issue of duplicative testing.

I am in favor of single-payer system. In looking at other countries that have instituted that system, they have given a standing in the hierarchy, if you will, for the general practitioner so that if a general practitioner refers a patient to an institution, there may be less likelihood that all of those tests that we do will be repeated.

I know here on several occasions physicians that work in health care have done medically appropriate workups on patients and then referred them to a secondary facility for care for, say, cancer surgery. The patient upon arriving will have all of those tests repeated. That is where the costs are being driven up. They are not being repeated or the costs are not being driven up because a person has a fear of malpractice lawsuits. We are using reputable laboratory facilities and pathological services. The costs are driven up because these are teaching institutions and they are tools for teaching.

I wanted to make a point about the cost of medical schooling for people that graduate and the need for paying back loans. I think we can address that by revamping the National Health Service Corps and allowing for more people to pay back their loans by putting time in as President Clinton has set forth.

Mr. McDERMOTT. Let me followup on that because I actually made a note to myself, Dr. Weiss's suggestion that we have to do something about getting people to go into general practice or family practice kinds of methods of giving health care. Short of saying, "pay them more money," what else do you think is possible?

You mentioned status. I wonder, do you have suggestions in terms of what needs to be done in order to make it possible?

Dr. WALKES. Being a physician, I am sure you have heard people back in your medical school training or residency training talk about this person came through a GP and they say that such and such and so-and-so, they are not accorded the same kind of respect that some of the other specialties are. People feel that they will make more money, frankly, as specialists.

I think if we can somehow get back to the notion that people become doctors to provide medical care to patients rather than to make a lot of money, that might help.

Mr. McDERMOTT. The term of my medical school was an LMD, local medical doctor. Everybody knew what a disparaging term that was.

I wonder-I don't know if the National Health Service Corps is the way, but I think it is one of the issues. But another thing that strikes me is that in medicine you work as your teachers taught you. Every medical school today is founded largely by physicians practicing medicine and showing students how it is done, and you are taught by tertiary care or tertiary care physicians in the medical school and most people go out and practice an awful lot like the people they trained under, which builds in some difficult situations.

It is difficult to get people out into a training situation where they are actually working with a primary care physician. Medical schools struggle with that, some with more success than others. The dean at the University of Washington was the only graduate of Johns Hopkins that had gone into primary care in his class. Everybody else was a specialist in that class.

I think that says a lot about what the training does and why you get these kinds of problems. It is not so much malpractice as the way we are trained, frankly.

Dr. WALKES. I have from time to time had students in my clinic who were at various stages in their medical training. That is beneficial for the students. It gives them a chance to see what community-based medical practice is like and the constraints that we live under. I think more of that would help bring people to the practice of community-based medicine.

Mr. MCDERMOTT. It strikes me that one of the ways that you may do that is to force medical schools to turn out general practitioners. Tie their Federal funding to those kinds of restrictions. I think if we do not find some way to put the pressure on medical schools, they will continue to do what they have always done.

Thank you, Mr. Chairman.

The CHAIRMAN. Did you want to make a comment on that, Dr. Williams?

Dr. WILLIAMS. Yes. I am a residency program director in family medicine and my job is to recruit and retain family physicians and to get across the training to the practice sites. I have difficulty answering questions about money because I have gone to major sites in California and Florida, giving them a high reimbursement rate that we could not give the District of Columbia.

As to recruitment and retention of family practice, I did a survey of our first-year class of our university and I noted that 50 percent of the individuals that raised their hands when asked if they would like to go into primary care, they had about 19 individuals who would like to go into family practice specifically.

We give a course at Howard, introduction to patient care, where we introduce family practitioners as lecturers. We try to give them that role model. The major competition is the eye, ear, and the prestigious practices that go along with the medical school.

However, this year, 1993, 1994, we will be introducing our predoctoral program in family medicine as a required rotation in medicine at the medical school to acknowledge family practice as a career opportunity. We sold that idea to our curriculum committee with the idea that it would enhance support by scholarship and other funds by doing this and by having a class that graduates with job opportunities.

I think across the country that for the 2,000 individuals that graduate on a yearly basis from family medicine, there are almost 20,000 jobs available. So, we can get our residents in and out of our program with a high degree of skill, and we do fill and we did match them with institutions. So, we do feel that this is a major turn for students from the, I guess, higher reimbursable practices or the lifestyle reimbursable practice into primary care.

Mr. MCDERMOTT. It is interesting to hear that. I know that the statistics from 1989 to 1993 dropped from 23 percent going into primary care down to 19 percent. If you begin to see a reversal, that is a good sign.

You are correct, on the West Coast where we have had much more experience with well-run HMO's, at least one HMO I know hired 95 physicians last year in family practice. They could not find enough people, but they are paying well. They are not skimping.

I think that is where the question of how much money you have to pay to get somebody to go into that kind of practice, given the

kind of debt that they have-the figures that I have heard, at most State medical schools the debt is $50,000 and at private schools it is closer to $100,000 and that drives a big decision if you were 25 years old and you are dragging a sack of debt of $50,000, you have to consider that debt.

The CHAIRMAN. If the gentleman would yield, Kaiser is paying $110,000 to start for a family practitioner. If it is $70,000 here, that is a big difference putting up with the climate that we have and the lousy football team.

Is that what we have to pay to get people to give that up in the District? It may be an answer.

Dr. Weiss, you may have the last word.

Dr. WEISS. In regard to the downward trend in primary care, last week I attended the Association of Internal Medicine Program Directors, and the students opting for general internal medicine is down 25 percent. Those that are going into internal medicine are going as a pathway to the subspecialties.

That is a frightening figure. Only 3 percent of our seniors are electing general medicine.

Mr. MCDERMOTT. I think one of the distinctions that people do not make is the difference between a family practitioner and a general practitioner and an internist. Those terms are used interchangeably very often, but in fact they represent a total different mindset in terms of what the training is and what people's expectations are when they get out in practice.

The CHAIRMAN. One other thing; I have to lay this one to rest. As a consumer who has often said I did not know the difference between a proctoscope and a horoscope, I have suggested to you never in my adult life, even as a little child have I asked anybody to stick a needle in me to give me a proctoscopic examination, to give me something to drink or to enter into my body in any other way to make me glow in the dark. I do not like that kind of thing. But if you tell me to do it, I am very obedient, but I do not think us patients like it. I do not want any tests. You tell me to take the test, I will, but doctors always feel that it is my fault that I am coming around to demand these things. I do not want to hurt, and I want you to make me well, but whatever you decide and however you decide to do it, I will do it, but I think you guys are the ones who decide what happens to me.

Now, if I quit smoking, I help myself along. If I exercise, I help myself along. I understand that part of it. But for the most part of it, it is you guys who have to find us.

In this outreach thing, I have this feeling under managed care that if we did not pay that first capitated dollar, until you got the patient in and got the workup done, then we would get more outreach. But when you let somebody sign up 5,000 people, and then do not do anything, I think the incentives are wrong. If you do not get anything until you reach out, I think we would get something done here.

If I tell a doctor he is not going to get anything until he brings in people who need the prenatal care-look at this fellow who was doing the cataract surgery. He was finding people who had two or three cataracts per eye.

I know that we can get outreach. But in a more serious vein, I know that in the District of Columbia we have real evidence as shown by you all, by way of thanking you, to help this community extend the access to all of its residents, and I also have a hunch that perhaps we can do that, deal a little creatively.

It is a pretty small community. All of us know each other. Those of us who are politicians live here. You all work here. It is not that big; 600,000 people is not a lot of people. Every one of us represents a district that big. I have a feeling that with the hospitals close by, we might be able to do something creative. We have a very willing mayor and a willing District who want to extend the benefits to all their citizens. I do not want to get in and interfere with anything that the President is going to do. But I think if we can continue this dialogue, and I hope we will, we will be able to do something here that we are proud of.

I have heard that some States are hurrying up to get their medical reform bill passed in a hurry. But I think we can do a good job here. Next time, you guys get to be first.

Thank you for being here. I hope that we can work together on this. I think that we can be helpful to our District here. Thank you very much for being here.

The committee will adjourn.

[Whereupon, at 3:30 p.m., the committee was adjourned.]

[The following additional material was subsequently received for the record:]

TESTIMONY TO THE U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON THE DISTRIC OF COLUMBIA

REP. PETE STARK CHAIRMAN

The Medico-Chirurgical Society of the District of Columbia is very pleased to be able to present to the Committee on the District of Columbia and its initiative on healthcare reform for the citizens of the District of Columbia. Our Society is the oldest active African-American Medical Society. Founded in 1884, it represents approximately 700 physicians in the District of Columbia as well as other African-American healthcare providers of other professions. We have had a long history of service to the citizens of the District of Columbia and have worked in relationship with the hospitals and medical facilities of the District of Columbia as well as the re-imbursement providers in various capacities. We plan to continue to work with them in providing service to our community.

Our concern with the healthcare reform is that in the past we have had a reactionary position to changes in the health care administration as well as re-imbursement initiatives as others in positions of authority have dictated our role in providing these services as well as our reimbursement. Other areas of concern include - third party re-imbursers, the defensive medicine position that we must maintain, the availability of patients, the location of our practices being circumcised to certain areas of the City and the availability of hospital affiliations because of either location or changes in credentialing requirements. We are very sensitive to the changing needs of our patients and especially with universal access, we are sensitive for the puralistic functions of having our patients and doctors mutually agree on healthcare services. We believe that managed care maybe a mechanism of cost containment. However we feel that continuity of care and the bond between patients and physicians should continue despite the changes in the payor system.

We are also sensitive to the educational loan debt burden that many of the African-American physicians must bear since many individuals who enter the healthcare field find limited resources among their families and therefore must secure loans to continue their education. We feel that the cost containment policies of health care reform should consider the debt burden of these physicians in their re-imbursements and allow more African-American physicians to enter the medical educational and service arena. As stated we believe that a capitation type of re-imbursement as a form of managed care not be the only form of re-imbursement but also a case management type which will allow patients and physicians to contract between themselves. We note that a single payor system may eliminate many of the administrative costs of delivering healthcare, however, we are fearful of any system that does not allow the patient or physician to have input into its administration. We note that under the current system of reimbursement for health services that approximately $7 to $10 per claim is required to process the re-imbursement for the physician. This charge may reflect only a single patient visit which in terms of current medicaid reimbursement may reflect only one-half of the re-imbursement required to submit or re-submit the claims for a medicaid patient. Therefore, a single payor or modification with standardization of the current claim system would enhance the efficiency of the administration of medical care and there in the long run bring the cost of services under control. Professional Liability through Torte Reform if introduced in the District of Columbia may also bring a reduction of the cost of malpractice payments and may eventually make cost control a reality.

We note through prior testimony that the District of Columbia has identified several wards and census tracts as underserved health care shortage areas, and it is hoped that physicians who are recruited to serve in these areas may be provided

certain incentives similar to the ones that medicare provides to the physicians in rural areas or alternatives such as less re-imbursement restrictions we well as the District of Columbia availability or National Health Service Core sites.

Our membership continues to endorse the operation of the D.C. General Hospital not only as a healthcare provider for services in Wards 5, 7 & 8, but as a significant part of the training of the physicians of the District of Columbia. Many of our members including myself have trained at this institution and find this a valuable resource of education as well as an opportunity to serve our community especially where violence and severe diseases impact the cost of operation of such a noble facility.

We thank the Committee on the District of Columbia for allowing the Medico-Chirurgical Society to make this presentation and we look forward to working with your committee in the future to provide appropriate healthcare reform to the citizens of the District of Columbia.

STATEMENT TO THE COMMITTEE ON THE DISTRICT OF COLUMBIA

From: COMMUNITY HEALTH CARE, INC.
3020 14th Street, NW
Washington, DC 20009

Submitted by: Charles M. Mathis
Interim Director

THE ORGANIZATION

Community Health Center, Inc. (CHCI) is a non-profit 501(c) 3 community-based health services organization supported and operated in conformance with the requirements of Section 330 of the United States Public Health Services Act. CHCI is the only federally qualified and funded community neighborhood health center in the District of Columbia. It operates two primary sites: the Upper Cardozo Health Center and East of the River Health Center. The Upper Cardozo Health Center is located in the heart of a rapidly changing and diverse international African-American/Latin/ African/Asian (specifically Vietnamese) neighborhood with special racial, ethnic, cultural and linguistic needs. East of the River Health Center is located in Ward 7 in the midst of a primarily African-American community plagued by high infant mortality rates, rapidly spreading sexually transmitted diseases, drug abuse and violence.

CHCI has been providing preventive and primary care services in the city's high-risk target communities since 1968. CHCI plays a unique role as the major private provider of health care services for a significant portion of the city's medically underserved and economically disadvantaged patient population which includes a significant number of undocumented aliens and other high-risk patient target groups such as HIV/AIDS, substance abusers and women prone to high-risk pregnancies. The organization employs 15 full and part-time physicians and mid-levels who provide 63,000 encounters to over 19,000 patients per year.

The corporate organization is modeled after health maintenance organizations providing preventive primary care and case management services to all ages, but especially targeted to high-risk population groups. Traditional medical services, including Obstetrics & Gynecology, Child/Adolescent Health Programs, Pediatrics and Adult Medicine, as well as special services addressing problems such as infant mortality, teenage pregnancy, substance abuse, health care needs associated with homelessness, HIV/AIDS, nutrition and mental health are delivered on-site.

THE PROBLEM - EAST OF THE RIVER

East of the River Health Center is located in Ward 7, a community fighting to survive in a troubled urban environment. According to the 1990 Census, the Ward 7 service area has 72,924 people, 96.9% of whom are African-American. There were 21,017 women of childbearing age, defined as females 10 to 44 years old. These women deliver an average annual number of live births of approximately 1,574. During the period 1988-90 the average number of infant deaths was 34 per year. Ward 7 had an Infant Mortality Rate of 21.8%. The principal causes of death were related to short gestation and unspecified low birth weight. The women of Ward 7 are at a high risk for demographic, socio-economic, environmental, behavioral, and medical risk factors. More than three-fourths, of the delivering mothers (76.2%) are not married. They experience a high incidence of STDs (gonorrhea and syphilis). HIV infection is rapidly increasing. One out of every 67 births revealed HIV infection in 1990. Many women drink during pregnancy, they are prenatal substance abusers and smokers. More than one-third (35.1%) had less than a high school education.

This alarming profile is caused by many factors which create this negative social environment. Violent crime, poor housing conditions, homelessness, increased child abuse and diminishing employment and training opportunities indicate adverse social conditions that reduce the overall quality of life and help to produce high infant mortality statistics

THE PROBLEM - UPPER CARDOZO

The District of Columbia is a microcosm of the world. However, in contrast to the "melting pot" characterization of the United States in general, the District is more of a mosaic or salad bowl, where individual characteristics are retained and must be appreciated as part of the whole. Not only is the District the nation's capital, but it is also host to and the new home of people from every corner of the globe; people speaking many different languages and dialects. Throughout our vibrant, dynamic city there are large pockets of Caribbean, Latin American, South American, Asian, European and African culture. Each culture has its own distinct values and perceptions about health, illness and major health care problems such as substance abuse and HIV/AIDS.

The Hispanic and Asian (specifically Vietnamese) populations are the fastest growing ethnic minority communities in Wards 1 and 2 (Adams-Morgan) which are serviced by CHCI's Upper Cardozo Health Center. Migration resulting from civil wars in Central America has contributed to the rapid growth of the District's Hispanic population. CHCI finds itself in the midst of changing racially, ethnically and linguistically diverse communities.

During the 1990's, a substantial number of undocumented immigrants settled in the Adams-Morgan area. Mayor's Order 86-91 was issued to ensure access to those services and benefits funded solely by District appropriation and available to all residents of the District. The order, "Clarification of Benefits Available to Non-Citizens or Individuals without U.S. Residency Status", limits inquiries by District government agencies to information necessary for establishing eligibility for District government services. While the District maintained the lowest refugee welfare dependency rate in the country, many refugees can not afford to pay for health care, and therefore look to organizations like CHCI for their health care needs. Although not obligated to do so, CHCI has opted to comply with the Mayor's Order in the spirit of community service. This policy, however, does have a significant affect upon corporate resources.

In addition to the Hispanics, there is a growing influx of Asian and African immigrants, principally from Vietnam and Ethiopia, but also representing most of the West African nations arriving in the District each day. These people have largely settled in the Adams-Morgan area of the city which is said to be the most integrated community in America. Because the Upper Cardozo site is located in the heart of this international neighborhood it has had to respond to its special needs. Given this service area environment, it is imperative that the health center find creative ways to offer comprehensive, culturally and linguistically appropriate medical and social services to the new and unique ethnic and culturally diverse medically-underserved patient population.

PROGRAM DESCRIPTION AND NEEDS ASSESSMENT

EAST OF THE RIVER - Resources available to pregnant women and infants in the service area are severely limited. There are only two city operated neighborhood health centers (Benning Heights and Hunt Place); the East of the River Health Center; and Ophelia Egypt Clinic (a Planned Parenthood facility). No hospital is located in Ward 7, however, many women who live in Ward 7 deliver at D.C. General Hospital which is located in the adjoining Ward 6. D.C. General also operates the Women's Services Center in cooperation

with the D.C. Alcohol and Drug Abuse Services Administration which treats women for drug and alcohol abuse, and also offers a smoking cessation program. Service area capacity is further limited by the inability of providers to effectively followup referrals and to provide case management and outreach home visiting services. This problem can be corrected by (a) enhancing the service delivery capacity of CHCI and (b) by adding additional providers willing to offer coordinated primary care and inpatient hospitalization services. The most immediate need is to improve and strengthen East of River Health Center's existing system of care. Funding is needed to:

- Expand social worker involvement to a larger client base
- Improve Case Management services
- Fund Obstetrics and Gynecology services
- Support the Comprehensive Perinatal Care Program
- Institute a parenting and family support program for men
- Provide outreach and program coordination functions for inpatient and outpatient services
- Fund Transportation services
- Add additional nutrition services
- Provide Ultra Sound services
- Expand Dental services and include more teaching opportunities
- Add more mid-level Provider staff positions

UPPER CARDOZO - Language and the lack of coordinated service delivery are becoming barriers to care. CHCI has identified an immediate need for full-time Vietnamese interpreter services. Currently, the City's Refugee Center provides an interpreter to assist with Asian patients. The frequency of such visits has reached a level where full-time interpreter services are needed. Additionally, while a large percentage of CHCI staff are bi-lingual (Spanish/English), we have found that coordination of care with our primary referral hospital is being hampered due to communication problems. This has discouraged our pregnant Hispanic patients from presenting for delivery at our participating hospital. Therefore, on-call interpreters are needed to accompany Hispanic patients to the hospital to assist with communication between patients, their families, and providers during delivery. Funding is need to:

- Hire a full time interpreter for Vietnamese patients
- Conduct outreach services to diverse patient population groups
- Develop literature and marketing materials that explain the range of health care and social services available at the health center to non-English speaking immigrant groups
- Expand the immunization program to specially targeted immigrant patient population groups
- Develop health promotion and disease prevention information for distribution to diverse patient population groups
- Provide 24 hour on-call triage services
- Provide outreach and program coordination functions for inpatient and outpatient services
- Expand social worker involvement to a larger client base
- Fund Obstetrics and Gynecology services
- Support the Comprehensive Perinatal Care Program
- Institute a parenting and family support program for men

SUMMARY

The socio-economic conditions and the diminished health status of District residents offers an outstanding opportunity to demonstrate the unique capabilities of a community health center to rapidly respond to changing community needs. This application represents a similar opportunity for the Congress of the United States to demonstrate its commitment to community-based health services in

partnership with the District of Columbia and Community Health Care, Inc. in direct response to the gap in our service delivery capacity.
While the Committee on the District of Columbia, meets today to consider the potential impact that health care reform will have on the residents of the District of Columbia it should consider that the existing indigent health care system is in serious need of resources.

Community Health Care, Inc. is in need of additional funding in the amount of $3,000,000 over the next three years. These funds will allow us to operate both of our facilities, East of the River and Upper Cardozo Health Centers, to meet the needs of the uninsured while Congress debates the numerous proposals to reform the United States health insurance system. The entire amount of funding would be for patient services, and program expansion.

As the crisis of the uninsured has escalated during the past four years our centers have been forced to serve, due to increased demand, an additional 2,000 to 3,100 users each year. This increase in demand has caused serious financial hardship to our corporation to the point that our Governing Board is considering closing one of our sites to remain solvent. This is a decision each one of our Board Members is reluctant to make, considering that they were forced to close our third site, Shaw Community Health Center, in early 1992 due to a mounting deficit.

Community Health Care, Inc. is asking the Committee on the District of Columbia to consider a direct appropriation to CHCI as part of its District of Columbia contribution.

KEY COMMUNITY HEALTH CARE, INC. STAFF **(202) 745-4444**

Charles M. Mathis	Acting Executive Director
Levi B. Miller, III	Deputy Director
Albert B. Grandy, Jr., CPA	Finance Director
Jimmie Drummond, M.D.	Clinical Director

SUPPLEMENTAL INFORMATION

SUBMITTED TO: THE HONORABLE PETE STARK, CHAIRPERSON
THE COMMITTEE ON THE DISTRICT OF COLUMBIA
1310 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515

SUBMITTED BY: COMMUNITY HEALTH CARE, INC.
3020 14TH STREET, NW
WASHINGTON, DC 20009

CONTACT PERSON: CHARLES M. MATHIS, INTERIM DIRECTOR
(202) 745-4444

SUMMARY:

Community Health Care, Inc. (CHCI) a non-profit 501(c) 3, Corporation, funded under Section 330 of the United States Public Health Services Act, offers testimony, on the state of the indigent health service system within the District of Columbia.

CHCI operates two primary health centers within the District of Columbia, the Upper Cardozo Health Center and the East of the River Health Center primarily serving the economically disadvantaged and uninsured. During 1992 the CHCI Governing Board was forced to close a third site, Shaw Community Health Center, due to a mounting deficit brought on by a crisis demand for uncompensated services.

We are asking the Committee on the District of Columbia to consider funding the health center, while it debates the numerous proposals to reform the United States health insurance system. These funds could be part of the Appropriation to the District of Columbia. These funds would be used to expand patient services, increase access, and eliminate poor health outcomes.

CHC - SUMMARY REQUEST

		FY 94 EOR	FY 95 EOR	FY 96 EOR	TOTAL	FY 94 UC	FY 95 UC	FY 96 UC	TOTAL
SUPPORT FOR COMPREHENSIVE PERINATAL PROGRAM									
A.	OBSTETRICS AND GYNECOLOGY SERVICES	$180,000	100000	100000	$380,000	$165,000	85000	85000	$335,000
B.	MID-WIFE SERVICES (MID-LEVEL)	60,000	60,000	60,000	180,000	60,000	60,000	60,000	180,000
C.	CASE MANAGEMENT SERVICES (R.N. S)	48,000	48,000	48,000	144,000	48,000	48,000	48,000	144,000
D.	NUTRITIONAL SERVICES	32,400	32,400	32,400	97,200	32,400	32,400	32,400	97,200
E	MEDICAL SOCIAL WORKERS	36,000	36,000	36,000	108,000	36,000	36,000	36,000	108,000
F.	ULTRA-SOUND TECH SERVICES	16,800	16,800	16,800	50,400	16,800	16,800	16,800	50,400
G.	EQUIPMENT (ULTRA-SOUND,SONOGRAM,F.C.T.S)	121,200	0	0	121,200	121,200	0	0	121,200
DENTAL PROGRAM									
A.	DENTIST SERVICES	31,200	31,200	31,200	93,600	31,200	31,200	31,200	93,600
B.	HYGIENIST SERVICES	20,400	20,400	20,400	61,200	20,400	20,400	20,400	61,200
C.	EQUIPMENT (DENTAL CHAIRS)	20,000	0	0	20,000	20,000	0	0	20,000
OUTREACH PROGRAMS									
A.	PARENTING/FAMILY SUPPORT SERVICES - INPATIENT/OUTPATIENT SERVICES - MEDICAL SERVICES FOR MEN - 24 HOURS TRIAGE SERVICES	19,200	19,200	19,200	57,600	19,200	19,200	19,200	57,600
B.	DIVERSE PATIENT SUPPORT SERVICES - IMMUNIZATION FOR IMMIGRANT PATIENTS	0	0	0	0	36,000	36,000	36,000	108,000
C.	INTERPRETER SERVICES (ASIAN)	0	0	0	0	15,000	15,000	15,000	45,000
D.	MARKETING/HEALTH PROMOTIONS SERVICES - DIVERSE PATIENT POPULATIONS	15,000	15,000	15,000	45,000	15,000	15,000	15,000	45,000
TRANSPORTATION PROGRAM									
A.	TRANSPORTATION SERVICES	21,600	21,600	21,600	64,800	21,600	21,600	21,600	64,800
B.	PATIENT VANS	23,000	0	0	23,000	23,000	0	0	23,000
	TOTAL REQUEST ALL SERVICES	$644,800	$400,600	$400,600	$1,446,000	$680,800	$436,600	$436,600	$1,554,000

CHC - SUMMARY REQUEST

PERSONNEL	FY 94 EDF	FY 95 EDF	FY 96 EDF	TOTAL	FY 94 UC	FY 95 UC	FY 96 UC	TOTAL
2.00 SOCIAL WORKERS	$30,000	$30,000	$30,000	$90,000	$30,000	$30,000	$30,000	$90,000
2.00 REGISTERED NURSES	40,000	40,000	40,000	120,000	40,000	40,000	40,000	120,000
2.00 NUTRITIONIST	27,000	27,000	27,000	81,000	27,000	27,000	27,000	81,000
2.00 NURSE MID-WIFES	50,000	50,000	50,000	150,000	50,000	50,000	50,000	150,000
1.00 PARENTING/FAMILY COORDINATOR	16,000	16,000	16,000	48,000	16,000	16,000	16,000	48,000
1.00 MUTLI-CULTURE OUTREACH COORDINATOR				0	30,000	30,000	30,000	90,000
1.00 ULTRA SOUND TECH	14,000	14,000	14,000	42,000	14,000	14,000	14,000	42,000
1.00 DENTIST	26,000	26,000	26,000	78,000	26,000	26,000	26,000	78,000
1.00 HYGIENIST	17,000	17,000	17,000	51,000	17,000	17,000	17,000	51,000
2.00 DRIVER - PATIENT TRANSPORTATION	18,000	18,000	18,000	54,000	18,000	18,000	18,000	54,000
	278,000	238,000	238,000	714,000	268,000	268,000	268,000	804,000
FRINGES BENEFITS @ 20%	47,600	47,600	47,600	142,800	53,600	53,600	53,600	160,800
CONTRACTUAL								
2.00 OB/GYN (INCL. MAL-PRACTICE)	150,000	100,000	100,000	350,000	165,000	85,000	85,000	335,000
1.00 INTERPRETER (ASIAN)	0	0	0	0	15,000	15,000	15,000	45,000
EQUIPMENT								
2 ULTRA-SOUND MACHINES	40,000			40,000	40,000			40,000
2 SONOGRAMS MACHINES	70,000			70,000	70,000			70,000
4 DENTAL CHAIRS	20,000			20,000	20,000			20,000
COMPUTERS - P.C.'S (TRACKING)	11,200			11,200	11,200			11,200
	141,200	0	0	141,200	141,200	0	0	141,200
TRANSPORTATION								
1 PATIENT VANS	23,000	0	0	23,000	23,000	0	0	23,000
OTHER								
PRINTING/HEALTH PROMOTIONS	15,000	15,000	15,000	45,000	15,000	15,000	15,000	45,000
TOTAL REQUEST	$644,800	$400,600	$400,600	$1,446,000	$0	$560,800	$436,600	$436,600	$1,554,000

CHC - SUMMARY REQUEST

	FY 94	FY 95	FY 96	
UPPER CARDOZO HEALTH CENTER	$660,800	$436,600	$436,600	$1,554,000
EAST OF THE RIVER HEALTH CENTER	644,800	400,600	400,600	1,446,000
COMBINED FUNDING REQUEST	$1,725,600	$837,200	$837,200	$3,000,000

HEALTH SYSTEM REFORM & THE DISTRICT OF COLUMBIA
COMMITTEE ON THE DISTRICT OF COLUMBIA
US HOUSE OF REPRESENTATIVES
HEARINGS HELD APRIL 19, 1993

STATEMENT FOR THE RECORD
by
JONAS MORRIS

The announcement for this hearing said it had been called to address the potential impact of health care reform on District residents. Rather than address my remarks to which type of health insurance mechanism, as identified by the Chairman - managed competition, pay-or-play, or single payor - would be best for the District of Columbia, I have taken a different subject. I focus my remarks on improvements in the capacity of the health infrastructure in the District of Columbia needed to make health care reform successful. Without the proper foundation, almost any health care reform can flounder.

Witnesses who presented testimony during the April 19 hearing adequately addressed the issue of health insurance reform and gave a full description of the availability of care and health care providers in the District of Columbia, the availability of health insurance or other means for paying for health care, the cost of health care services in the District, and the burden DC hospitals are shouldering because of the uncompensated care they provide.

My remarks will cover the following health reform issues:

* Health planning and health care reform
* Medicaid and DC residents
* Primary care issues in the District
* The role of non-profit clinics
* Mental health services
* Health Corners
* Public health efforts

HEALTH PLANNING & HEALTH CARE REFORM

For health care reform to be successfully implemented, there must be an adequate health care infrastructure and that infrastructure should be carefully constructed. If there are insufficient resources in place when the reform plan is implemented (or if the mechanism to create those resources is not in place) the services demanded will probably exceed the system's capacity to deliver those services.

This issue is a very real and serious problem for the District. There is insufficient capacity to provide care to the approximately 127,000 persons in the city who are without health insurance (although many of these individuals find some level of health care through non-profit clinics, clinics operated by the Commission of Public Health, and hospital emergency rooms). If each of these persons were suddenly given access to the usual health care system, it probably would not have the capacity to meet the demand. Having an effective health planning program is one way becoming prepared for such an eventuality.

Health planning in the District of Columbia is carried out principally through two offices: the State Health Planning and Development Agency (SHPDA), recently relocated and now part of the Commission of Public Health, and the Office of Health Planning and Development in the Commission of Public Health.

The SHPDA health planning process at this time is severely inadequate to its task and must be strengthened before any health reform package is implemented, as the following discussion illustrates.

SHPDA has a statutory mandate. By law, it has responsibility for evaluating and issuing (or denying) certificates-of-need (CONs) which are necessary, generally, before a new health service can be started, stopped, significantly altered or enhanced, or major new medical equipment can be purchased (this generally does not apply to physicians in private practice, but does apply to clinics, particularly if they wish to get reimbursed by the DC medicaid program). Applications for certificates-of-need are first reviewed by the SHPDA staff, then presented to the Statewide Health Coordinating Council (SHCC) which can recommend that they be approved as presented, denied or modified. The recommendations of the SHCC are advisory and are designed to provide guidance to the SHPDA Director, who by law has sole responsibility for granting or denying a CON, or granting it with modifications.

Until recently, SHPDA was a separate agency in the DC Department of Human Services. With the recent reorganization of the Department, SHPDA was moved to the Commission of Public Health, but it nevertheless retains the same statutory authority, which includes granting CONs for mental health and some other services outside the purview of CPH. The City Council in 1992 passed, and the Mayor signed, legislation (Health Services Planning Program Act of 1992; Bill 9-43; DC Act 9-322) recreating the CON procedure.

SHPDA is also responsible for writing and updating, with substantial input from the community, the State Health Plan. Generally speaking, the state health plan is a roadmap that lays out the full range of health services that will be needed over the next five or ten years. SHPDA and the SHCC use this roadmap as they review applications for certificates of need.

The CPH Office of Health Planning and Development, an office whose responsibility is limited to matters under the purview of the Commission of Public Health, has responsibility for planning and developing programs and services for the Commission, including the public health clinics. The Commission, as you are aware, is in the process of being recreated in a Department of Public Health as a result of the enactment of legislation in 1992. However, CPH is now reaching beyond this limited mandate, and appropriately so. Recently it sponsored a conference on "Health Care Reform in the District of Columbia," which was designed to focus on changes needed to help support successful implementation of health care reform.

The conference particularly focused on developing objectives presented in Healthy People 2000 (promulgated in 1991 by the US Public Health Service) and designing strategies to implement those objectives. Healthy People 2000 is primarily a system for identifying targets for improving the health status (e.g. "By the year 2000, 95 percent of all persons under the age of 18 will have an identified primary health care provider."). It is not a process for rearranging the configuration of hospital services or identifying the number of home health care agencies may be needed by the year 1995, for example.

As yet, neither the Mayor, Director Gray nor Commissioner Akhter has stated how the new law will be implemented, or whether the two health planning efforts will be combined. If the City, however, is to adequately prepare for a reformed health care system as envisioned by the Clinton Administration's Health Care Reform Task Force, this anomaly needs to be corrected soon. My own view is that the kind of health planning for which SHPDA is responsible (that is, a master plan and a CON process) is needed in order for a state or city to have an effective and workable health care system.

There are a number of problems with the present SHPDA arrangement at this time. These include:

* SHPDA staff has been decimated in recent years, with the result that much needed work does not get done.

* The State Health Plan is out of date (largely because of staff shortages), with the result that staff reviewing CON's are required to make recommendations based on standards that do not reflect current realities.

* The post of SHPDA director has been vacant since last summer and there appears to be no work in progress to fill the vacancy.

The District's health services (both public sector and some of the private sector) are under stress. This is due largely to the extraordinary pressure to provide services to a population that has very serious health needs, including a large population of persons without health insurance, many of whom have AIDS or are HIV positive. This was very adequately described by some of your other witnesses.

An effective state health planning program, including a CON process, is necessary to build and maintain an effective health system infrastructure to ensure that all residents are able to get appropriate health care on a timely basis. Such a health planning process can ensure that broad planning parameters are adhered to, provide the opportunity for a structured debate on significant changes to the City's health infrastructure and help to identify and work toward effective and constructive compromises. In the eighteen months that I have been a SHCC member there have been several such efforts with some limited success.

The District of Columbia's state health plan should be updated and the CON process strengthened in order to help build the capacity in the District to provide everyone with the health services they need in a reformed health system in a reformed health system.

MEDICAID AND DC RESIDENTS

It appears that the District of Columbia is not signing up to the extent anywhere near possible residents who could qualify for medicaid.

A recent GAO report, "District of Columbia: Barriers to Medicaid Enrollment Contribute to Hospital Uncompensated Care" (HRD-93-28), describes steps that could take to help gain access to medicaid reimbursement for some of the now uncompensated care provided by District hospitals. It also appears that there is a significant amount of health care provided outside hospitals to people who are poor or otherwise do not have insurance to pay for health care services that might be reimbursed by medicaid if the individuals were enrolled in the medicaid program. A number of the non-profit health clinics in the District providing care to this population are now taking steps to enroll their clients in the medicaid program if they are eligible. This effort is described below.

It is quite likely that the medicaid program will be substantially modified by the Clinton Administration's Health Care Reform proposal, but that prospect does not make the issue moot. The DC Commission on Health Care Finance, as you know, is implementing a program requiring that all AFDC beneficiaries (who for the most part are eligible for medicaid coverage) have a primary health care provider. This is an important program and should be implemented swiftly. All individuals who are eligible

for medicaid should be enrolled in the program as soon as possible. Additional steps need to be taken by the City to accomplish this.

CPH/PHS PRIMARY CARE TASK FORCE

The DC Commission of Public Health recently entered into a cooperative agreement with the US Public Health Service to build a much stronger primary care system in the District. Under this agreement, CPH is developing a primary care network of public and private, non-profit clinics and other providers in the District of Columbia to focus on the best ways to improve primary health care services throughout the entire city for the population that is largely without health insurance and often poor. The Commission has convened the DC Primary Care Citywide Task Force to provide oversight to the project. All of this should enhance the primary care infrastructure in the city. This is an important step to prepare for health care reform.

This effort complements another ambitious CPH program, Healthy Start, a PHS supported effort which is focusing on building a prenatal, infant and child care health services program in Wards 7 and 8. This program can have a significant impact on these communities east of the Anacostia River by attempting to ensure that all children have proper immunizations, that youngsters - both male and female - understand the problems associated with teen pregnancies, that when a teenager does become pregnant it is crucial that she have access to a complete prenatal program and that both she and the infant will have proper care after delivery. Healthy Start must also focus on AIDS and HIV infection, the most severe health problem facing the city.

But there are other severe problems with which the Healthy Start program must deal: violence experienced by youngsters as well as adults, either as witness or as the object of the assault; general preventive health care so as to cut down on crisis medicine in hospital emergency rooms; special care for children with serious chronic, often genetic, diseases that require an extraordinary level of attention and resources to manage successfully; mental health care to help bring some stability to the lives of children growing up in very difficult circumstances.

Hopefully the Healthy Start initiative will make it possible to bring about systemic changes in the City's public health care system so that these services become permanent and durable and will operate successfully for years to come.

NON-PROFIT DC HEALTH CLINICS

Non-profit health clinics in the District of Columbia provide a crucial and badly needed health care to an important segment of the District's population. Members of this population, for the most part, are the same as those who use the clinics operated by the Commission of Public Health.

Many of the non-profit clinics in the District recently joined together to form the Coalition of Non-profit DC Health Clinics so as to jointly work together to increase their capacity to more effectively provide health care to persons who use their services. These clinics, jointly, provide tens of thousands of hours of health care annually to persons who, for the most part, would either not receive needed health care, add to the crowd already seeking indigent care in the emergency rooms of the city's hospitals or add to the already excessive burden confronting clinics operated by the Commission of Public Health.

The non-profit clinics are asking CPH for access to the City run lab to do the necessary diagnostic work required for many of their clients. They are also asking for the ability to purchase medications from the CPH pharmacy, and for effective support services from DC General Hospital, such as x-rays and other diagnostic services clinic physicians and other health care practitioners are unable to provide. When measuring the capacity of the District of Columbia to provide health care services to the entire population, the work of these clinics must be taken into account.

I am working with members of the Coalition through Health Services Development Inc., a non-profit, tax exempt agency of which I am director, to help them achieve some of these objectives so as to enhance their capacity to deliver health care to the population they serve. We are helping the clinics install a computer-based program that determines whether a client may be eligible for medicaid and other entitlements. This program itself may result in successfully get reimbursement for a significant amount of health care that now is provided free. (See Appendix B for a list of the members of the Coalition of Non-profit DC Health Clinics).

MENTAL HEALTH SERVICES

The Clinton Health Care Reform Task Force has indicated that mental health services, including services to deal with substance abuse, will be covered to some extent under the forthcoming plan. Although, these services are outside the responsibility of the Commission of Public Health they need to be included in the City's health planning process. Unfortunately, the District's public system of mental health care is in disarray and needs substantial improvement before it will have the capacity to provide effective mental health services to those seeking them in the public sector.

The Commission has been without a Commissioner for nearly a year now, despite repeated urging by the community that the Kelly Administration take immediate and effective steps to name a qualified person to fill that vacancy.

Additionally, the Kelly Administration and the Commission on Mental Health Services have failed to respond effectively to an agreement signed with the Dixon Implementation Monitoring Committee. The Dixon Committee has been involved for many years in litigation with the City to provide more effective public mental health services to DC residents. The Dixon Committee has petitioned the Court to appoint a special master so that progress can be made on improving services to persons experiencing mental illness designated in the law suit. This is an untenable situation and needs to be corrected quickly.

HEALTH CORNERS

There are some very bright health care spots in the District. The program of Health Corners operated in at least five of the City's public housing units, with more to come, are a very creative and energetic program that meets many important objectives. This is an ambitious program that trains residents of public housing units to serve as health advocates in Health Corners, an apartment set aside in public housing units. Health advocates staff health corners on a regular basis and provide health education and some screening to their neighbors in the housing units. When health care by a trained professional is called for, the health advocate links the person with one of the City's public health clinics, a not-for-profit, private clinic or other health care facility where the individual can get the treatment he or she needs.

This program was recently brought to the attention of the Clinton Administration's Health Care Reform Task Force, which, I am told, found considerable merit in the program and indicated it was the kind of primary health care system that it would like the federal government to support in a reformed health care system.

Health corners are a product of the public housing community themselves. Part of the initial impetus - and a lot of the energy that keeps them going today - comes from the Kenilworth-Parkside Housing Development. But a lot of other organizations have helped along the way, including the DC Cardiovascular and Renal Disease Consortium (DC CARE), the Centers for Disease Control and Prevention, and the DC Commission of Public Health.

PUBLIC HEALTH EFFORTS

Earlier I discussed some of the traditional curative health care services provided by public health clinics under the auspices of the Commission of Public Health. In the present health system, public health has a dual responsibility. Its responsibilities will change in a reformed health care system. At this time, CPH has both the responsibility either to provide clinical health care services, or cause to be provided, to people who otherwise do not have access to these services and responsibility to see that certain health education, promotion and preventive health activities are carried out.

In the reformed health system, because most people will have access to clinical health care services through a universal system of care, public health responsibility for providing individual clinical curative and preventive health services will be significantly diminished.

Thus, in a reformed health care system, public health prevention and education programs become a more prominent part of the public health agency's responsibility. These activities, which may be targeted at the entire community or to a defined subset of the community, are intended to improve health or provide protection from disease and injury. This objective will be accomplished through public education, regulation of behavior, and/or outreach services to individuals or populations identified as having a high risk of contracting a disease or diseases or experiencing injury or other adverse health conditions. Examples of such public health activities include public education on HIV and AIDS, mandatory seat belt use, and follow-up of persons suspected of having tuberculosis.

In a reformed health system, public health agencies will continue to monitor access to appropriate care and intervene to assure services for all, whether they are provided directly by public agencies, through contract with private programs, or by mandate due to federal or DC law. Special, hard-to-reach populations, such as people who are homeless, will be the particular focus of public health agencies.

The Clinton Administration Health Care Reform Task Force has indicated that there will be a defined role for public health agencies in the reformed system. Thus, as we talk about health care reform in the District of Columbia, we need to keep this new role in mind, plan for it and shaped it.

APPENDICES

Appendix A

Biographical Information about Jonas Morris

Jonas Morris has over twenty-five years experience working with health, mental health and aging issues and programs through consulting, lobbying, teaching and as a writer, journalist and program analyst. He has experience in the non-profit, for-profit and public sectors, extensive expertise in planning, governmental process, and the development of consensus in policy making.

He is a long-time resident of the District of Columbia and President of Health Services Development Inc., a non-profit, 501c3 organization, which specializes in projects designed to develop improved access to and delivery of effective and appropriate health and related services for low-income and disadvantaged persons living in the District of Columbia. HSD also focuses on projects designed to improve the infrastructure of health services delivery and capacity in the District of Columbia.

He is active in many associations and organizations in the District concerned with health issues: Mayoral appointee to the Statewide Health Coordinating Council, member of the governing council of the Metropolitan Washington Public Health Association, member of the boards of directors of the Health Equal Access League (HEAL DC) and the DC Mental Health Association, and member of DC CARE (Cardiovascular and Renal Education Consortium) and the Health and Human Services Coalition of the District of Columbia. In addition, he is a member of the Primary Care Task Force organized jointly the DC Commission of Public Health and US Public Health Service.

His address is 1742 Riggs Place, NW, Washington, DC, 20009-6113 (202-797-0647).

Appendix B

COALITION ON NON-PROFIT HEALTH CLINICS

Clinica Del Pueblo, 1470 Irving St. NW, Washington, DC 20005

Community of Hope Health Services, 1417 Belmont St. NW, Washington, DC 20009

Community Medical Care, 1118 9th St. NW, Washington, DC 20001

Health Care for the Homeless, 1234 Massachusetts Ave. NW Washington, DC 20005

Mary's Center, 1844 Columbia Rd. NW, #204, Washington, DC 20009

Planned Parenthood, 1108 16th St. NW, Washington, DC 20036

S.O.M.E., 71 O St. NW, Washington, DC 20001

Spanish Catholic Health Clinic, 3055 Mt. Pleasant St. NW Washington, DC 20009

Washington Free Clinic, 16th & Newton Sts. NW, Washington, DC 20010

Whitman Walker Clinic, 1407 S St. NW, Washington, DC 20009

Zacchaeus Free Clinic, 1329 N St. NW, Washington, DC 20005

Committee On The District of Columbia

Hearing

National Health Insurance Reform and
Its Implications for the District of Columbia

Monday, April 19, 1993

Room 1310A
Longworth House Office Building
Washington, D.C. 20515

by

The Prudential Insurance Company of America
Mid-Atlantic Group Operations
2800 North Charles Street
Baltimore, Maryland 21218
(410) 554-7100

The Prudential strongly supports the Managed Competition approach to meeting the health care needs of District of Columbia residents. As the nation's largest insurer, we have made a national commitment to managed care because we believe it is the best way to provide Americans with high quality care at a reasonable cost.

Currently, we offer three different managed care products in the Washington-Baltimore area: a 40,000-member group model Medicaid HMO in Baltimore; a 100,000-member mixed model commercial HMO in Central Maryland, Northern Virginia, and in the District; and an innovative 120,000-member managed PPO which features primary care provider/gatekeepers in the same area.

About 6,900 D.C. residents are members of the PPO and about 2,100 are IPA HMO members. While we are Maryland's largest Medicaid HMO, we do not serve District Medicaid recipients.

Specific Responses on Managed Competition

1. If the entire District of Columbia were a HIPC and, for sake of argument, all 600,000 residents were required to be in it, would you bid to be an AHP offering the basic benefit package?

In theory, yes. However, to be more specific, we would have to know more about the rules that would govern the HIPC's operation. There also are many other questions that would have to be answered. For example: Would the HIPC serve those who lived in D.C. or worked in D.C. -- or both?

2. Roughly, what do you estimate your monthly premium would be compared to your average monthly premium now?

Compared to our average monthly premium for employed persons, our premium for a D.C.-wide HIPC would increase because it would serve people now on Medicaid, a sicker population that uses more medical services. The actual premium would depend upon a variety of considerations about the health, age and gender of the overall D.C. population. By the way, this assumes that there would be only one price for the entire HIPC. We feel that a risk adjustment mechanism is necessary to protect AHP's that served low-income populations (see below).

3. Currently, only Chartered Health Plan offers insurance to 16,000 of the District's 100,000+ Medicaid population -- an IPA model HMO. Are there requirements placed on insurers by the Insurance Commissioner that limits the ability or interest of insurers to contract for Medicaid enrollees? If similar restrictions were extended to all AHPs -- like a requirement on insurers to contract with District hospitals -- how would this influence your decision as to whether to participate in a D.C. HIPC?

There are obstacles to participating in the Medicaid market, but they are not placed there by the Insurance Commissioner. Most prohibitive is the fact that when we investigated participating in the D.C. Medicaid market, we discovered that rates paid were lower than Maryland's, even though there is no evidence that the costs of caring for D.C. residents would be any lower than Maryland residents.

There were other unattractive contract provisions as well. For example, the District requires that, if an HMO serves Medicaid recipients, all the HMO's providers must serve Medicaid recipients in all their offices. We knew that some of our providers, who do not currently serve Medicaid recipients and whose practices are located in areas where there are few Medicaid recipients, would drop out of our network if we required them to serve Medicaid recipients. Rather than jeopardize our provider network, we elected not to participate. Maryland has no such requirement, but allows us to designate a provider

network for Medicaid which is chosen to be located in the necessary communities to promote access to care.

In Maryland, the State also effectively protects HMOs against the impact of certain catastrophic illnesses like AIDS by offering "stop loss" provisions in its contract. D.C. offers no such protection.

In terms of restrictions upon AHPs, we'd have to examine each one to determine whether, singly or cumulatively, they would influence our decision whether to participate in a D.C. HIPC. For example, we have no objection in theory to contracting with District hospitals -- we do already -- but we would not wish to be required to contract with all D.C. hospitals. To do so would destroy our ability to require a hospital to meet quality of care standards, to say nothing of negotiating reasonable fees. For example, we have high standards for quality assurance. But a hospital that couldn't be cut from the network could ignore them and we would be powerless to do anything about it.

4. My understanding is that Chartered Health Plan enrolls only the AFDC-eligible Medicaid enrollees. AFDC-Medicaid enrollees make-up roughly one half of the total Medicaid population in the District. How does the amount of the premium received by Charter for Medicaid enrollees compare to the average cost of all Medicaid enrollees? Would enrollment of the non-AFDC eligible Medicaid population require adjustment to the premium currently received by Chartered?

This question is specific to Chartered Health Plan.

5. Do you have the facilities currently in place to serve the entire population in an HMO? If not, how long would it take you to get them in place? What areas of the City are you least prepared to serve in the first year of the contract?

It's unlikely that any single HMO could boast facilities sufficient to serve the entire population of D.C. That doesn't mean that capacity couldn't be developed, however. We have experience in bringing up large networks -- even when multi-state -- relatively quickly for large employer groups. Depending on the extent of the network needed, it would take several months, ideally a year, to build a quality network, complete credentialling, and install quality assurance systems.

6. Would you contract with any of the City's teaching hospitals? (And if not, what would you expect to happen to teaching hospitals?) Would you contract with National Rehabilitation Hospital for Rehabilitation services?

Again, in theory, we have no problem contracting with teaching hospitals -- we contract with Johns Hopkins and Georgetown now. Much would depend upon the hospital's willingness to work cooperatively with us in a managed care environment.

7. Under managed competition as it has been defined, government support for the Medicaid population would be limited to the price of the lowest priced plan. Assume you are the lowest priced AHP, and for whatever reason, all other AHPs bid $100 more per month/$1200 per year. Do you agree with me that almost immediately you would be the AHP used by the current Medicaid population and the poor and near-poor.

Under your scenario, yes. However, you are quite clearly making the best argument for having different prices paid to HMOs for caring for different patient populations. There must be a "risk adjustment" mechanism in place for higher risk populations with the increased cost of care for the Medicaid population being borne by the government. We would not like to see the poor and near-poor given no choice but the single lowest bidder.

Our recommendation would be to allow a choice among at least the three least expensive whose premiums would be adjusted based on some multiplier. For example,

we know that low income has resulted in higher health care costs. If the HMO quotes a price of $X for the employed population, the HMO should be paid for the unemployed at a rate of $X times a multiplier. The historical cost data for the expense of caring for the Medicaid population is available to the District. It would not be difficult to determine an equitable adjustment based on that information.

8. Are you prepared to provide primary care and other services in the areas of the City where most of the poorer residents are located? If not, when could you?

We are not currently prepared, but could be. The biggest unknown would be the current providers' willingness to work with managed care. Again, we would need about a year -- from the time when it became clear what the HIPC's rules and regulations were -- to recruit a quality network.

We caution against assembling a network too hurriedly. The Medicaid population is a vulnerable one and safeguards must be in place to monitor and support high standards of care.

9. A proposed function of the HIPC is to make risk adjustments to protect against adverse selection in any one plan. Do you believe that if you were the lowest priced AHP in an areas where the poor might be concentrated, that the Government would be able to sufficiently risk adjust your contract so that you would be able to survive without an upward adjustment of monthly premiums?

In effect, the risk adjustment represents an increase in monthly premiums. It is possible for the government to sufficiently risk-adjust so that premium increases to the member do not occur. The more successful the adjustment mechanism, the less necessary are the premium increases to the members. We believe that any such mechanisms should be developed in cooperation with the industry.

10. and 11. How would a District of Columbia HIPC/AHP work across State lines? In other words, would your network of providers be moderately or severely hurt if you had to use providers just in D.C.?

Do you believe a Capitol Area HIPC could only work if it covered a larger SMSA-type area? Where would draw the lines?

10. and 11. Until national reform occurs which would foster regional HIPCs, each jurisdiction is limited to what it can do within its own boundaries. We support the effort to create conditions in which regional HIPCs would be possible. At that time we strongly believe that any D.C. HIPC should be extended to the entire metropolitan area in order to reflect existing commuter patterns.

12. Would you describe how you would hold down costs after the initial bid?

After the initial bid, we would hold down costs the way HMOs always have -- by managing care. We would work, as we do every day, to provide high quality, cost-effective care to all our members through capitated provider networks, intensive case management, careful utilization review, aggressive contractual agreements, etc.

<u>All Payor/Single Payor Approaches</u>

All the many criticisms of these approaches have already been voiced, ranging from inability to control costs or utilization to the creation of extensive and expensive bureaucracies and the shifting of expenses first to employers and then to the taxpayer. We frankly do not believe that these approaches merit the Committee's consideration. Managed Competition creatively harnesses market forces to work in favor of both the consumer of and the payor for quality health care.

FINANCING A NATIONAL HEALTH CARE PROGRAM
with
COST CONTAINMENT

Submitted By

Vernon C. Smith, M.D.

Philosophy:

The National Medical Association in its infinite wisdom, went on record several years ago, mandating a National Health Care System embracing; (1) Single Payor, (2) Universal Access and Coverage, (3) Freedom of Choice of Provider, (4) Affordable Care for all people, and (5) Comprehensive benefits. The National Medical Association believed that these principles could be realized most effectively through a National Health Insurance Program.

The business economic profit motive associated with health care investments; in providing care - services, pharmaceuticals, health care supplies - equipment, financing, and administrative services is the greatest single factor in escalating or inflating health care costs. In order to control spiraling health care costs, the profit motive must be removed. In order to remove the profiteering and contain costs in the Health Care System we must establish a National Health Care, single payor system. If we seriously believe that access to adequate health care is a Human Right, then we must establish a National Health Insurance, single payor, universal access system.

In order to develop realistic financing and cost containment for a National Health Care Single payor system we must address four (4) general areas: (1) Methodology for revenue production. (2) Research in developing measurements for measuring patient treatment outcomes and practice parameters useful in achieving quality care for all groups of patients, not limited to patient case - cost comparisons. (3) Establishment of a National Health Service Commission to negotiate fee schedules for all providers and suppliers of the Health Care Service(s) and consumable (products), Nationally and uniform(Figure 1). (4) Elimination of insurers administrative profits and government micro-regulations necessitating unwieldy bureaucracies at both public and private sectors.

Practice Model

The National Practice Model embracing a National Health Insurance would essentially be a non profit, controlled system to provide all health needs for all Americans. Medicare and Medicaid would be absorbed into the National Health Insurance.

The present system of freedom of provider choice(s) (including hospitals) would remain intact. Reimbursements would be on a scheduled-fee-for service. The scheduled-fee-for service would be determined nationally by the National Health Service Commission.

The National Health Commission would be appointed by the president with congressional approval after input from the appropriate organizations concerned with health care services. The Commission would have at least one representative from each component provider in the health care profession, legal profession, business profession, insurance profession, religion, education, labor and consumer group. Policy relating to fees, benefits, standards of care, and Health System regulations would be made by the National Commission. Each Region of the United States would have a Regional Commission, a microcosm of the National Commission. The National Commission would entertain Regional recommendations and proposals in effecting a uniform universal health care system. The term of office of the Commission would be four (4) years with a two (2) year overlap of the Regional and National Commission(s). Regional Commission(s) would be required to have membership representative of each state consisting of the governor or an appointee in addition to the profession representation.

Ancillary services i.e. laboratory. radiology and procedures, etc. would be on a fixed fee payment for in-hospital care as well as outpatient care. A single payor system would eliminate the need for competing health insurance plans that use benefit restrictions and patient access inconvenience as a means for controlling costs.

All claims for reimbursement would be handled by one government office in respective regions of the United States. Present Health Insurance companies could contract with the federal and state governments to administer claim processing. Contracts with claim processors (private health insurance companies) would be negotiated by the National Health Service Commission. Claim contractors would not be engaged in regulatory activity. There will be no discrimination in participation of providers based on size or practice plan or location. HMO's and Managed care groups could continue to function, but as administrators of health provider groups rather than health care providers. Since all reimbursements for care will be uniform and equal, there will be no incentive to form large "health holding facilities" to compile profits, using clever marketing strategies and complex service access regulations(Figure 2). Pharmaceutical prices would be controlled by the National Health Insurance Commission, as well as medical equipment prices and medical supplies.

Hospital fees, Nursing Home fees, Extended Care, and Maintenance Care Facilities fees would be negotiated regionally through the Health Service Commission. This method would not only monitor and control exorbitant expenditures, but it would also serve as a clearing body for controlling hospital services that may be unnecessarily duplicated or not cost effective(Figure 3).

REVENUE - FINANCING

Financing the National Health Care Single Payor System can be accomplished without significant tax increase and a reduction in out of pocket expense by the health care consumer. Areas of revenue generation are as follows:

1. Utilization of present budget allocation earmarked for Medicare - Medicaid.
2. Health Insurance Premium contribution by the consumer and employee at a reduced cost.
3. Sin Tax on cigarettes and alcohol.
4. Cost control on fees, prices and products (drugs).
5. Elimination of private sector administrative profits.
6. Preventive medicine and Wellness benefits to accrue as unused annual deductible will serve as investment credits for the consumer to cover health care costs in the event of unemployment, catastrophic illness, etc.
7. Medicare insurance premiums for consumers with a retirement annual income over $80,000.00 a year.

8. States will be capitated a negotiated rate by the Regional Health Service Commission for those patients that qualify for medical assistance, e.g. Welfare, Homeless, Unemployed, etc.

9. Workmen Compensation treatment will be reimbursed on a DRG schedule based on type of injury. These DRG fees/related to acceptable length of disability, will be determined by the Health Service Commission. Workmen Compensation Treatment centers would be established at Community Hospitals under special DRG contracts to serve those patients when private providers did not wish to participate.

10. Community Health Clinics, School and Hospital based clinics would function as a physician based practice, receiving funds from National Health Service claims and would not require additional federal and state subsidy.

11. Professional Education training stipends would be removed from the health care budget and administration health care services financing. Rather Education and training i.e. Resident training funding should be placed under the bureau of health manpower.

12. National Tort Reform with Caps on awards, claim review, etc. Malpractice Insurance premiums actuary based on a national liability physician pool rather than local physician pools.

REVENUE METHODOLOGY

PRESENT NATIONAL HEALTH CARE EXPENDITURE	APPROX. $800 BILLION
UNITED STATES POPULATION	APPROX. 235 MILLION
MEDICARE - DISABILITY POPULATION	30 MILLION
UNINSURED	35 MILLION
MEDICAID	10 MILLION

Estimated Insurable Employees in U.S. 108.38 MILLION

Present Approx. Cost of Ins. Premium per year (Employer + Employee) = $6,000.00 x 108.38 = $650.280 BILLION

(EMPLOYER CONTRIBUTION $4,000.00/YR. EMPLOYEE $2,000.00/YR)

REDUCE COST OF PREMIUM TO .50% UNDER NATIONAL HEALTH INSURANCE.	$325.140 BILLION
PRESENT BUDGET FOR MEDICARE AND MEDICAID	$268.000 BILLION
SIN TAXES	$ 13 BILLION
ADMINISTRATIVE SAVINGS SINGLE PAYOR	$ 9 BILLION
DRUG COST CONTROL*	$ 30 BILLION
PROVIDER COST CONTROL*	$ 21 BILLION
HOSPITAL COST CONTROL*	$ 45 BILLION
REVENUE TOTAL	$ 711 BILLION

* Based on a 50% and 14% present inflation rate respectfully

PRESENT NATIONAL HEALTH CARE COST	$800	BILLION
LESS COST SAVINGS UNDER SINGLE PAY		
DRUG COST CONTROL	30	BILLION
HOSPITAL COST CONTROL	45	BILLION
PROVIDER COST CONTROL	21	BILLION
ADMINISTRATIVE, PVT. INS. SAVINGS	9	BILLION
TOTAL SAVINGS	105	BILLION

ESTIMATED COST FOR FUNDING THE PRESENT 35 MILLION UNINSURED, APPROX. $60 - $90 BILLION DOLLARS; LESS 105 BILLION = 15 BILLION DOLLAR RESERVE.

(See Figures 4 through 11 , Exhibits for Methodology)

Figure 1

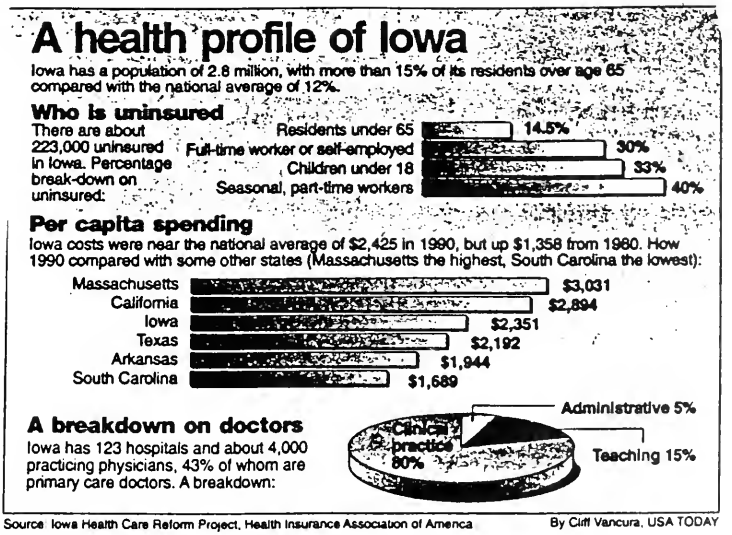

A health profile of Iowa
Iowa has a population of 2.8 million, with more than 15% of its residents over age 65 compared with the national average of 12%.
Who is uninsured
There are about 223,000 uninsured in Iowa. Percentage break-down on uninsured:
Residents under 65 14.5%
Full-time worker or self-employed 30%
Children under 18 33%
Seasonal, part-time workers 40%
Per capita spending
Iowa costs were near the national average of $2,425 in 1990, but up $1,358 from 1980. How 1990 compared with some other states (Massachusetts the highest, South Carolina the lowest):
Massachusetts $3,031
California $2,894
Iowa $2,351
Texas $2,192
Arkansas $1,944
South Carolina $1,689
A breakdown on doctors
Iowa has 123 hospitals and about 4,000 practicing physicians, 43% of whom are primary care doctors. A breakdown:
Clinical practice 80%
Administrative 5%
Teaching 15%
Source: Iowa Health Care Reform Project, Health Insurance Association of America
By Cliff Vancura, USA TODAY

Figure 2

Mid-Atlantic Medical Services Says Profit Rose 39% in 1992

Mid-Atlantic Medical Services Inc., a Rockville company that runs health maintenance organizations and other health services, reported that 1992 profit rose 39 percent, to $13.5 million (94 cents a share), from $9.7 million (68 cents) the year before.

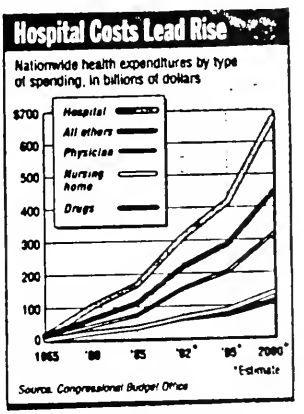
"While the local economy remained essentially flat, our total membership grew dramatically and our ability to manage critical costs became more refined," George T. Jochum, the company's president, said in a statement.

The company's revenue rose 46 percent in the year, to $579.35 million from $397.6 million in 1991.

Wash Post
Feb 9, 1993

Figure 3

On the one hand, "if you allow HMOS to lock up physicians, you could ultimately



wind up with too few HMOs," says Prof. Reinhardt. But allowing a doctor to work

Figure 4

CLINTON'S BUDGET

Here is a look at Clinton's requests in major budget categories compared with President Bush's requests, the spending Congress approved last year and Congress's plan for fiscal 1994.

SOCIAL SECURITY

OLD AGE, SURVIVORS AND DISABILITY INSURANCE

1993 Bush request	$302 billion
1993 Approved by Congress	$305 billion
1994 Clinton request	**$321 billion**
1994 Congressional plan	$322 billion

DEFENSE

INCLUDES THE PENTAGON AND DEFENSE-RELATED ACTIVITIES OF THE ENERGY DEPARTMENT

1993 Bush request	$291 billion
1993 Approved by Congress	$291 billion
1994 Clinton request	**$277 billion**
1994 Congressional plan	$277 billion

HEALTH, MEDICARE

MEDICARE, MEDICAID, RESEARCH, TRAINING, CONSUMER AND OCCUPATIONAL HEALTH AND SAFETY

1993 Bush request	$238 billion
1993 Approved by Congress	$238 billion
1994 Clinton request	**$265 billion**
1994 Congressional plan	$268 billion

INTEREST

INTEREST ON THE NATIONAL DEBT

1993 Bush request	$215 billion
1993 Approved by Congress	$202 billion
1994 Clinton request	**$212 billion**
1994 Congressional plan	$209 billion

WELFARE, JOBLESS BENEFITS

UNEMPLOYMENT COMPENSATION, FOOD STAMPS, AID TO FAMILIES WITH DEPENDENT CHILDREN, ETC.

1993 Bush request	$200 billion
1993 Approved by Congress	$209 billion
1994 Clinton request	**$215 billion**
1994 Congressional plan	$211 billion

EDUCATION

PRIMARY, SECONDARY AND HIGHER ED., OCCUPATIONAL, VOCATIONAL, ADULT EDUCATION, STUDENT LOANS

1993 Bush request	$50 billion
1993 Approved by Congress	$53 billion
1994 Clinton request	**$54 billion**
1994 Congressional plan	$52 billion

Figure 5

SINGLE-PAYER SYSTEM

As this table shows, over the past decade medicine has become increasingly bureaucratic. Many managers work to-

Employment in Health Care

Per 100,000 employees

	PHYSICIANS	MANAGERS	RATIO
1983	519	91	5.7 : 1
1985	492	106	4.6 : 1
1987	514	154	3.3 : 1
1989	548	188	2.9 : 1
1991	575	199	2.9 : 1
% increase from 1983 to 1991	10.8%	118.7%	

Source: The Bureau of Labor Statistics

ward keeping costs down through utilization reviews, mandated second opinions and the like. Yet this has driven the administrative costs of the U.S. health care system well over $175 billion per year and undermines the morale of physicians and the satisfaction of patients.

A tax-financed single-payer system with a global budget can eliminate many layers of bureaucracy and provide proven cost control mechanisms. President Clinton can begin the process of converting the system in steps. We could begin by covering children and pregnant women with a tax-financed health insurance, then expand the program to the uninsured, and finally include the entire country.

EZEKIEL J. EMANUEL
Oncologist and Ethicist
Harvard Medical School

Figure 6

Resources of the Drug Industry

Worldwide performance in 1991 of the 10 largest pharmaceutical companies. (Dollar figures in millions.)

	HEALTH CARE SALES	RESEARCH & DEVELOPMENT	U.S. SALES FORCE
Johnson & Johnson	$12,447.0	$ 980.0	2,011
Bristol-Myers Squibb	9,368.0	993 0	3,666
SmithKline Beecham	8,761.0	807.8	2,000
Merck & Company	8,019.5	987 8	2,700
Abbott Laboratories	6,876.6	666.3	3,140
Roche Group	6,664.3	1,027.7	1,300
Glaxo Holdings	6,318.4	883 5	2,250
American Home Products	6,220.3	431.0	2,382
Pfizer Inc.	5,941.3	756 8	2,231
Eli Lilly & Company	5,725.7	766.9	1,600

Source: Medical Advertising News

Figure 7 **OFF THE MARK**

INDUSTRY ANNUAL SALARIES, FROM A SURVEY OF 1,000 REGISTERED VOTERS

Mike Farrell and Robert Young in a scene from "Marcus Welby, M.D." Dr. Welby's patients never questioned his salary.

HEALTH PROFESSIONALS	PERCEIVED INCOME	FAIR INCOME	ACTUAL INCOME
Medical specialists*			
Anesthesiologists	$100,000	$80,000	$221,100
Radiologists	100,000	80,000	229,800
Hospital executives (500+ beds)*	150,000	100,000	235,800
Drug company chief executives	600,000	150,000	
Bristol-Myers Squibb			12,788,000
Abbott Laboratories			4,213,000
Eli Lilly			2,802,000
Insurance chief executives	400,000	115,000	
Aetna			1,120,500
Cigna			1,342,000
Travelers			1,173,858

* Actual income figures are industry averages

SOURCE Families U.S.A. Foundation

Figure 8

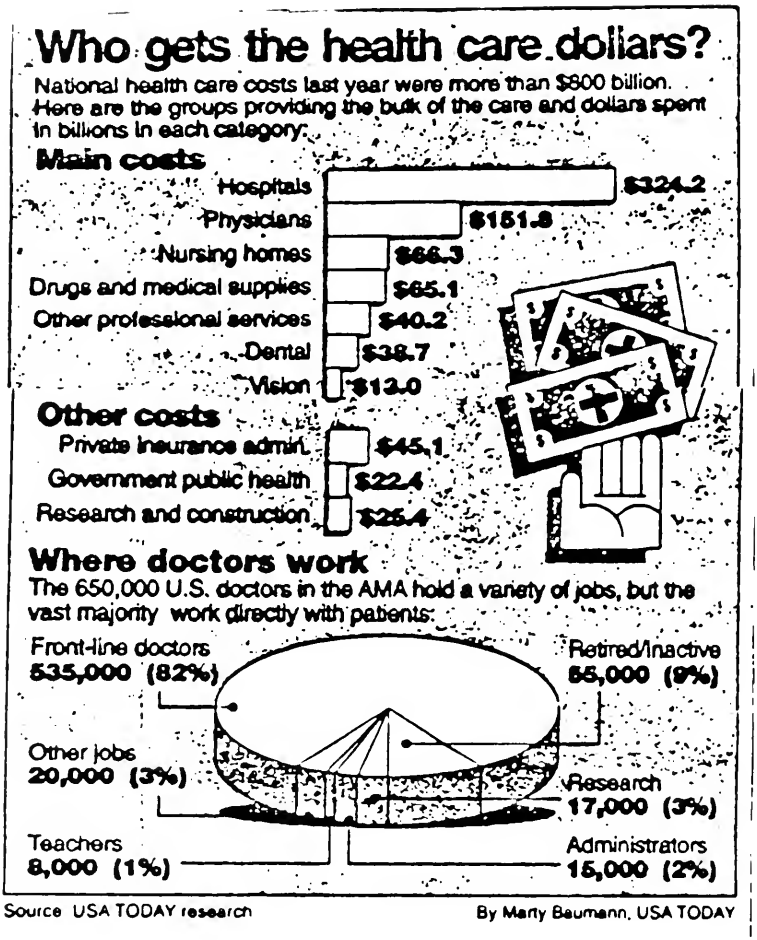

Who gets the health care dollars?
National health care costs last year were more than $800 billion. Here are the groups providing the bulk of the care and dollars spent in billions in each category:
Main costs
Hospitals $324.2
Physicians $151.8
Nursing homes $66.3
Drugs and medical supplies $65.1
Other professional services $40.2
Dental $38.7
Vision $13.0
Other costs
Private insurance admin. $45.1
Government public health $22.4
Research and construction $25.4
Where doctors work
The 650,000 U.S. doctors in the AMA hold a variety of jobs, but the vast majority work directly with patients:
Front-line doctors 535,000 (82%)
Retired/inactive 55,000 (9%)
Other jobs 20,000 (3%)
Research 17,000 (3%)
Teachers 8,000 (1%)
Administrators 15,000 (2%)
Source USA TODAY research
By Marty Baumann, USA TODAY

Figure 9

available to people. Right
re about the apples we eat
e use." And the public is
fits ignorance. —*Reported*
and Jane Van Tassel/New York
and Dick Thompson/Washington

Time
March 8,
1993

Figure 10

THE BURDEN ON INDUSTRY

Under today's tangled health finance system, employers pay an estimated $172 billion subsidy to cover the costs of uninsured or uncompensated medical care through higher insurance premiums and other charges. The burden isn't spread evenly because of differences in benefits and the availability of insurance:

INDUSTRY	SUBSIDY PER EMPLOYEE Dollars	EMPLOYEES Millions	TOTAL COST Billions of dollars
TRANSPORTATION	$1,025	3.51	$3.6
CONSTRUCTION	44	4.59	0.2
MANUFACTURING	623	18.46	11.5
TRADE	-134	25.33	-3.4
SERVICES	-194	28.32	-5.5
FINANCE	120	6.68	0.8
FEDERAL GOV'T	573	2.97	1.7
STATE/LOCAL GOV'T	337	15.41	5.2
OTHER	1,018	3.05	3.1

DATA: LEWIN VHI INC., U.S. BUREAU OF LABOR STATISTICS

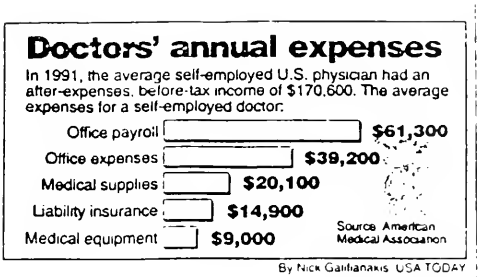
COVERING THE UNINSURED

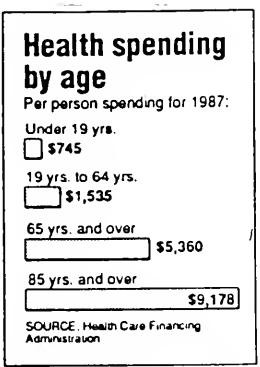
Health-care spending on uninsured individuals would rise to $71.5 billion from $41.4 billion now if they received private health insurance, according to health-care consultants Lewin-VHI Inc. This is how the additional $30.1 billion would be spent:

[illegible]	Billions
HOSPITAL CARE	
INPATIENT	$12.0
EMERGENCY/OUTPATIENT	4.4
PHYSICIANS	8.5
OTHER PROFESSIONAL	2.5
DRUGS & DEVICES	1.8
OTHER HEALTH SPENDING	0.9
TOTAL INCREASE	$30.1
CURRENT SPENDING	$41.4
SPENDING IF INSURED	$71.5

DATA: LEWIN VHI INC.

Figure 11





dren would have had the highest per

FINANCING A NATIONAL HEALTH CARE PROGRAM

PART II

Definitions

Single Payor - The proposed single payor system is likened to the Canadian System in that the Federal Government would be responsible for the payment of all health Care Costs. Unlike the Canadian system, this proposed system would not depend exclusively on tax dollars to fund health care. Employer and employee health insurance premium contributions would be mandated. Formulas, sliding scales would be established for small businesses premium contributions. Caps would be placed on insurance premium costs to employee and employers.

Most important, the proposed single payor system would eliminate profits made by private insurance companies from premium collections and health services reimbursements. The Government would collect and place all monies for health care in a health care trust fund. The government could contract with private insurance companies to process claims, compile statistics for health care providers, however, private health insurance companies could not participate in selling health plans in the basic National Health Care System.

Prospective health care costs would be determined a year in advance on a national level by regions. Methods used to predetermine health care costs (expenditures) by regions would consist of:

1. Payment (cost) history of geographical area by procedure(s), hospitalizations, office visits and diagnostic tests, and extended care.
2. Employment of Practice parameters, integrated with actuarial risk factors and relative value units (procedures).

The National Health Service Commission would negotiate, with regional organized medical groups (Associations, societies,etc.), a fee schedule for reimbursement of services for the fiscal year budgeted. The budgeted monies, held in a Federal Trust Fund would be appropriated through the National Health Service Commission for reimbursement of health services provided. Cost-over-runs would be factored in, in setting the prospective budget for the national health care service each year in advance (Global budgeting). Monitoring and enforcement of/for fee compliance, quality assurance, utilization would be performed through the respective medical associations. Raw data and information on the aforementioned topics would be collected doing claim processing and forwarded to the regional Health Service Commission for codifying, then sent to respective medical associations for application and enforcement.

A model for this concept of a nonprofit service commission, would be the Federal Energy Regulatory Commission. Similar to the Utility Regulatory commission, the National Health Service Commission would be a health service regulatory commission. All fees for patient care, including doctors, hospitals, nursing homes, ancillary care (laboratories, X-ray, etc.) would be determined by the Health Service Commission in consultation with the medical and hospital associations.

Each fiscal year, based on actual performance, there would be sound information available to make a realistic budget and cost projections up to a year in advance. Also providers would have the opportunity to request adjustments in practice parameters and relative value units based on practice experience the previous year. Insurance premiums would reflect actual cost of health care services and could be adjusted accordingly to give maximum benefit of savings to the subscriber rather than the insurance company.

FOR IMMEDIATE RELEASE
CONTACT: BRODERICK JOHNSON
TUESDAY, APRIL 13, 1993

COMMITTEE ON THE
DISTRICT OF COLUMBIA
1310 LONGWORTH HOUSE
OFFICE BUILDING
WASHINGTON, D.C. 20515
TELEPHONE: (202)225-4457

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN, COMMITTEE ON THE DISTRICT OF COLUMBIA, TO HOLD A HEARING ON POTENTIAL IMPACT OF HEALTH CARE REFORM ON DISTRICT RESIDENTS

WASHINGTON, D.C. -- The Honorable Pete Stark (D., Calif.), Chairman, District of Columbia Committee, U.S. House of Representatives, announced today that the Committee will hold a hearing on national health insurance reform and the implications for residents of the District of Columbia. The hearing is scheduled for Monday, April 19, 1993 at 10:00 a.m., in 1310A Longworth House Office Building.

In announcing the hearing, Chairman Stark said, "Like other urban centers, the District of Columbia has serious health care delivery problems. Through health reform, we want to improve the system -- not hurt it. This hearing will try to determine precisely what various reform options would mean for the District and for its residents."

Invited witnesses include representatives from the District of Columbia government, health insurers operating in the District, and District hospitals and providers.

Oral testimony will be heard from **invited witnesses only.** However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

There are numerous proposals to reform the United States' health insurance system. In this hearing, three health insurance reform proposals will be considered for their potential impact upon access to care and cost of insurance coverage for residents of the District of Columbia. The first reform option to be considered is "managed competition." The second proposal is "pay-or-play" with a Medicare-for-all type plan as the public plan option. The third is a "single payer" plan based on the U.S. Medicare system.

While the hearing will focus specifically on the District of Columbia, the information from this hearing will be useful to various States as they consider how these health insurance reform proposals might be implemented in their State.

(more)

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business, Thursday, April 15, 1993 to Broderick Johnson, Staff Director, Committee on the District of Columbia. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Committee office, 1310 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

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